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READINESS OF MILITARY MEDICINE

HEARING

BEFORE THE

INVESTIGATIONS SUBCOMMITTEE

OF THE

COMMITTEE ON ARMED SERVICES
HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

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CONTENTS

	Page
Carney, Hon. William, a Representative from New York	41
Mayer, Hon. William, M.D., Assistant Secretary of Defense (Health Affairs):	
Statement	10
Prepared statement	15
Nichols, Hon. Bill, a Representative from Alabama, chairman, Investigations Subcommittee:	
Statement	1
Prepared statement	2
Regula, Hon. Ralph, a Representative from Ohio:	
Statement	3
Prepared statement	5

READINESS OF MILITARY MEDICINE

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ARMED SERVICES,
INVESTIGATIONS SUBCOMMITTEE,
Washington, DC, Wednesday, September 18, 1985.

The subcommittee met, pursuant to notice, at 10:09 a.m., in room 2212, Rayburn House Office Building, Hon. Bill Nichols (chairman of the subcommittee) presiding.

OPENING STATEMENT OF HON. BILL NICHOLS, A REPRESENTATIVE FROM ALABAMA, CHAIRMAN, INVESTIGATIONS SUBCOMMITTEE

Mr. NICHOLS. The subcommittee will come to order.

The subcommittee is meeting today to receive testimony on the condition of military medicine. As you know, we have been concerned with problems in the quality of military health care for the past 2 years. Back in June 1983, I wrote Secretary Weinberger to request a thorough examination of all Department of Defense medical organizations and activities by the Inspector General of the Department of Defense.

Our concern at that time resulted from the criminal prosecution of the Chief of Anesthesiology of Walter Reed Army Medical Center, and the failure of the Army to relieve him of his duties after his plea of guilty. The Surgeon General of the Army who, at that time of the incident, was Commander at Walter Reed, was given a letter of admonition for failure to take action against the doctor.

More recently, however, the Chief of Cardiac Surgery at the Bethesda Naval Center has been charged with involuntary manslaughter in the deaths of four patients. Subsequent investigations revealed that this surgeon was recruited by the Navy, despite warnings by civilian authorities that he was not competent. As a result of that situation, censure of the Commander at Bethesda has been recommended by his Navy superior.

Serious as those instances are, I am even more concerned about a Department of Defense report of April 1984, which revealed the hospitalization of casualties from the bombing of the Marine Corps Battalion Landing Team Headquarters in Beirut in October 1985. The report concluded, and I quote: "Today the U.S. European Command has neither adequate medical readiness resources, nor effective joint plans for the resources it has."

If the resources and plans of the U.S. European Command are not adequate to provide care for victims of terrorist attacks, it seems to me that they certainly would not be adequate to respond

to a combat situation in Europe. Since combat readiness is the principal purpose for the existence of medical departments of the Armed Forces, the findings of the April 1984, report are of grave concern to this subcommittee.

I am also concerned over the Department of Defense classification of that report. I understand that there are certain limited areas of the report which are properly classified, but the Department of Defense classification of the entire report raises questions.

Military health care has also been a concern of other Members of Congress. The conference report on the fiscal year 1986 Defense authorization bill, in section 1207, would require the Secretary of Defense to submit a report containing the plan for revising the organizational structure of the military health care delivery system, in order to streamline the resource allocation process, improve the quality of medical care, to reduce the cost of that care, and to enhance medical readiness. I joined our colleague, Congressman Ralph Regula from Ohio, as the author of that report requirement, and we have invited Congressman Regula to participate in our hearing today.

Assistant Secretary of Defense for Health Affairs, Dr. William Mayer, has devoted considerable study and effort to improving the readiness of our health services. We have invited him here today to testify. We expect he will be able to inform the subcommittee of a number of issues—the readiness of military medicine, the joint planning to respond to wartime requirements, medical command and control, recommendations for establishment of a position of Command Surgeon at Headquarters U.S. European Command, the quality of medical care currently being provided military personnel, dependents, and retirees, the cost of military health care, and proposals for reorganization of the structure of the military medical system.

We are delighted to have both of these gentlemen as our witnesses this morning.

Congressman Regula, as a strong supporter of military medicine, we welcome you.

I understand you have a prepared statement, and we would be glad to hear from you at this time.

[Statement of Mr. Nichols follows:]

PREPARED STATEMENT OF HON. BILL NICHOLS

The subcommittee is meeting today to receive testimony on the condition of military medicine. As you know we have been concerned with problems in the quality of military health care for the past two years. In June 1983 I wrote Secretary Weinberger to request "A thorough examination of all Department of Defense medical organizations and activities" by the Inspector General of the Department of Defense.

Our concern at that time resulted from the criminal prosecution of the chief of anesthesiology at Walter Reed Army Medical Center and the failure of the Army to relieve him of his duties after his plea of guilty. The Surgeon General of the Army, who at the time of the incident was commander at Walter Reed, was given a letter of admonition for failure to take action against the doctor.

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Serious as those incidents are, I am even more concerned about a Department of Defense report of April 1984 which reviewed the hospitalization of the casualties from the bombing of the Marine Corps Battalion Landing Team Headquarters in Beirut in October 1983. That report concluded that "The U.S. European Command lacks a comprehensive, integrated plan for providing care to vicitms of terrorist attacks." The report concluded, "today the U.S. European Command has neither adequate medical readiness resources nor effective joint plans for the resources it has."

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Assistant Secretary of Defense for Health Affairs, Dr. William Mayer, has devoted considerable study and effort to improving the readiness of our military health services. We have invited him to testify today. We expect that he will be able to inform the subcommittee of: the readiness of military medicine; joint planning to respond to wartime requirements; medical command and control; recommendations for establishment of a position of command surgeon at Headquarters, U.S. European Command; the quality of medical care currently being provided military personnel, dependents and retirees (including the recent directive to utilize civilian peer review organizations as quality monitors); the cost of military health care; and proposals for reorganization of the structure of the military medical system (including department plans for implementation of the congressionally mandated reorganization study).

Dr. Mayer, we welcome you. I understand you have a prepared statement. You may proceed as you wish.

STATEMENT OF HON. RALPH REGULA, A REPRESENTATIVE FROM OHIO

Mr. REGULA. Thank you, Mr. Chairman. I commend you for your leadership on this issue. I know that you have a great concern also for the medical care of our individuals in the service.

I'd ask unanimous consent that my statement be made part of the record——

Mr. NICHOLS. Without objection, So ordered.

Mr. REGULA. I'd like to lead off by pointing out that, in a statement just 2 days ago, the Secretary of Defense, Secretary Weinberger, speaking to the DOD Health Conference, had these words to say:

A defense health agency has been proposed as a solution to the problems that occur in our system. We have attempted to address these problems by another means, through centralizing policy and resource allocation authority in the Office of the Assistant Secretary of Defense for Health Affairs. I believe this approach can and will work. However, establishing a Defense Health Agency is a step that I will certainly take if the mechanisms we have put into place are not able to correct the problems in preparedness, quality and the costs that we face today.

He went on to add, and I quote:

As a first principal, I care only about using our medical resources effectively for our troops at times when they may need it most. They deserve nothing less.

I think, Mr. Chairman, that you would echo that last statement certainly that the objective is good medical care for service people, and that that has no label, wears no particular uniform. I think that the individual needing help wants quality without regard to the uniform of the provider. The long-term challenge of deficits demands that we develop cost-effective approaches to defense, including medical care.

Historically, we've had 21 studies that I am aware of on this topic, and the recommendations in each of these has included a consolidation of health care facilities. I think just, for example, today 44 percent of the military facilities run under 50 percent occupancy. If these were civilian facilities being funded by medicare/medicaid, we would have a great outcry about how inefficient they are, and yet, this is an area that we are directly responsible for and we are tolerating this kind of inefficient occupation of our health care facilities. And I think it indicates clearly that we need to take a look for the long term as to how we can better organize the service health care systems.

The acceptable standard in the private sector is 80 percent occupancy, as a minimum, and yet in probably more than half of our facilities, we are running substantially under 80 percent.

Dr. Mayer said recently that one-fifth of the doctors, dentists, and clinical psychologists are unlicensed. And, again, if this were true in the private sector, there would be a great outcry.

It seems to me that we, in the Congress, as the managers, the board of directors, if you will, of the health care system, through legislative and appropriations actions, should recognize these problems and take steps to redress them. There are many stories that he told. For example, the incident in Grenada, when the Navy ships would not accept Army helicopters, with the wounded, is outrageous. The wounded serviceman needed help immediately, not when they could get flown there with a Navy rather than an Army helicopter. It goes back to my original statement that the injured person or the sick person does not really care what the label is; he or she wants help.

In an interview, the Assistant Secretary of Defense said armed services could care for only 3 out of 10 people who might be wounded in battle; and, again, as a management responsibility, the only reason for a Defense Department is to address the problems that would arise in providing for the security of this Nation, and it seems to me that we are not meeting that challenge when we have statements such as this, that perhaps in battle we could only handle effectively 3 out of 10 of the wounded.

Benefits would be very substantial to getting some type of consolidation. Both the Department of Defense and the Grace Commission estimate that we would save, as a minimum, $225 million annually, and at the same time, provide a better level of care for those that need it.

The possible solution to this is a one agency, within the Defense Department, having a responsibility for the medical delivery system. Now, obviously, in battlefield conditions you would have to have a continued responsibility with the Surgeon General in each of the services, because they are directly involved in that. But, as an overall management tool, it seems to me that consolidating the

health care delivery system within the armed services into one agency would be far more effective. You could eliminate duplicative services, we could have a better quality staff because, again, you would avoid the duplication that is characteristic of today's management plan.

Thanks to you, Mr. Chairman, the defense authorization contained language requiring that a plan be submitted within 6 months. That's the subject of your hearing today. And I would say to the credit of Dr. Mayer that it is obvious he is attempting through executive actions and orders to remedy some of the more grievous problems that exist in the health care delivery system at this time. But I believe that it is incumbent upon us as the directors, if you will, of the Defense Department, in our capacity as Members of the Congress, to provide a legislative framework that will make it easier to achieve these goals.

Clearly, the time for action is now, given the constraints that exist in the deficits. Dr. Mayer has indicated that we need to add to the $10 billion that we are spending presently for the health care system in the Defense Department, an additional $2.6 billion, to provide adequate assistance and adequate treatment for those in the service. This only amplifies the need for action that will result in savings rather than additional expenditures.

As a Congress, we've put pressure on the private health care sector through Medicare's prospective payment system and physician fee freezes to become more cost effective. I think we need to take the same attitude toward the private system. We must do everything possible to make military medicine more cost effective, while at the same time improving the level of care for those that serve this Nation in the uniform of the respective services. The objective must be to provide the best possible care at the least possible cost.

I think a consolidation of the health care delivery system within the services would go a substantial way in achieving those two goals.

Thank you, Mr. Chairman, for the opportunity to present my testimony and, again, commend you for your leadership in addressing this problem.

[Statement of Mr. Regula follows:]

PREPARED STATEMENT OF HON. RALPH REGULA

Today, we are confronted with a staggering federal budget deficit which continues to threaten the economic stability of our nation. The problem is further complicated by the responsibilities of the government to the people it serves ranging from health care to adequate defense.

Much has been said regarding deficit reduction but through the rhetoric there has arisen initiatives which represent a responsible balancing of cost and program quality. For the past three and a half decades one idea has continually resurfaced which would result in lowered costs and a better quality program. In twenty-one different studies it has been recommended that, in some form, there occur an organizational consolidation at the DOD level of the military health care system. In varying degrees all these investigations have noted certain reoccurring problems inherent to the military health care system. For example, 44% of the military facilities run under a 50% occupancy rate. Generally, private health care facilities consider an occupancy rate of 80% necessary for efficient operation. Other problems include a persistent inability to collect claims from third party insurers; duplication in facility construction costs and low utilization of graduate medical education programs.

Perhaps, even more alarming than the waste of federal tax dollars, is the questionable quality of care which arises under a system promoting interservice rivalries and inadequate standards of review. As noted in a February Reader's Digest article, numerous newspaper investigations and network news programs such as Sixty Minutes, military physicians have been found lacking the basic education and clinical credentials necessary to practice medicine. As late as March of this year the Pentagon's top health official, Dr. William Mayer, acknowledged that one-fifth of the doctors, dentists and clinical psychologists on active military duty lack a valid state medical license. Our military has some of the finest practicing physicians in the world but even one gross failure in selecting a qualified physician is unacceptable. Effective screening procedures must be implemented to prevent any future tragedies arising from medical fraud and incompetence.

The evidence is clear that greater coordination and cooperation is necessary between the military services to meet the basic needs of the military health care system in both its peacetime and wartime missions. Unfortunately, the history of military medical operations indicate that achieving these goals will not be accomplished by the separate military departments on their own.

Recent history illustrates the difficulties faced by a health care system residing in three separate departments. During the Grenada incident Navy officials refused to permit Army helicopters bearing wounded soldiers to land on the amphibious assault ship *Guam* because the Army pilots had not qualified under Navy instruction. In this case wounded soldiers had to wait until Navy helicopters were free to carry them out to the ship.

An unclassified foreword to a 1984 report by Navy Rear Adm. (Dr.) James Zimble, the Atlantic fleet Surgeon, speculates that the European medical system might not have been able to treat the casualties of the 1983 October bombing of the Marine barracks in Beirut if two hundred had required treatment rather than only eighty-one. In a March 1985 interview the Assistant Secretary of Defense for Health Affairs stated the armed services could care for only 3 of 10 people who might be wounded in battle today.

Confusion within the health command structure was characteristic of the treatment of the Beirut casualties. The senior medical officer in the area, Captain Morgan France, had ordered that all wounded be flown to the Royal Air Force Hospital at Akroitiri, Cyprus. Instead, the wounded were taken to Wiesbaden and Landstuhl. He later testified that the order had never been withdrawn. The Pentagon's own official investigation of the Beirut bombing, headed by retired Navy officer Adm. Robert Long, stated it was unable to discover who countermanded France's order.

These types of incidents repeated themselves throughout the crisis. Brigadier General Richard Hansen, the Air Force officer in charge of patient distribution, admitted the operation "pointed out a serious lack of a medical command structure" in Europe to assure "proper control of the medical aftermath of major disasters". In a separate memorandum Hansen sums up the underlying problem stating that Army, Navy and Air Force medical systems "all go our own ways" and that there is "no clout to direct when direction is needed".

Over the past two and a half years I have been working on a legislative proposal which, in my judgement, would reduce defense expenditures and improve efficiency within the military health care system. In February, I introduced legislation, H.R. 1136, which would consolidate the three armed services' health care systems into a central entity known as the Defense Health Agency controlled and directed by the Assistant Secretary of Defense for Health Affairs (OASDHA) in conjunction with the Surgeons General. The provision of medical care to military service personnel and their dependents, the single major peacetime role, will be directed by the OASD while all military field medical units will be under the respective Surgeons General.

Establishment of the DHA will not create a new bureaucracy within DOD. It consolidates the current system into a more efficient management structure. According to the Department of Defense and Grace Commission figures such an entity could save at least $225 million annually while improving health care delivery and medical preparedness.

Dr. Mayer has publicaly stated that the military health care system costs $10 billion a year. He estimates that an additional $2.6 billion is needed to rectify the current shortcomings of the system. I agree with Dr. Mayer that the situation must be rectified but as the prior Ranking Minority Member of the Appropriations Subcommittee on Military Construction for six years I found that tossing money at a problem doesn't guarantee its resolution.

Efforts are being taken to correct the recognized problems. By executive directive Dr. Mayer has issued accreditation requirements for all active-duty health profes-

sionals. The services have agreed to establish a joint planning staff in each of the European and Pacific areas of operations, with a single medical officer in charge. And much more is planned to be accomplished.

Dr. Mayer should be congratulated for his initiative and leadership. But much more remains to be done. Resources continue to be poorly allocated with surpluses in some areas and shortages elsewhere. Fixed facilities within the United States complete along service lines resulting in duplication of services and facilities.

Recently, the fiscal year 1986 Defense Authorization bill became law. In part, the legislation requires the Secretary of Defense to submit a report to Congress containing a plan for revising the organizational structure of the military health care system within six months from the date of enactment. The report must evaluate the various alternative structures they have proposed over the years. These include retaining the status quo; strengthening the Office of Assistant Secretary of Defense for Health Affairs; assigning an Assistant Secretary in each military department an additional responsibility for health affairs; a Defense Health Command, and a Defense Health Agency.

Along with many of my colleagues, I anxiously await the findings of this study. Far from being another in a long line of reports I am confident it will provide both an organizational framework and the stimulant to act in correcting the current deficiencies within the structure. Whether by the implementation of a Defense Health Agency or some other alternative the time for action is at hand.

Mr. NICHOLS. Thank you, Mr. Regula. We appreciate your interest in this matter, and I believe Dr. Mayer is going to comment on the report that you asked for. Certainly, we have some questions that we are going to propound to him. Mr. Carney, any questions?

Mr. CARNEY. Thank you, Mr. Chairman. Thank you, Ralph, for that very interesting testimony. There are two things that run in my mind, and you have been looking at this very, very carefully, and I must admit that I have yet to have the time that I would like to have put into this subject.

Mobilizing. When you go into a unified service, what impact would that have on mobilization?

Mr. REGULA. I don't see that if it is properly structured organizationally, that it needs to be a problem. As a matter of fact, if you have an effective system that will provide care for all the services, care for all the services, without labeling it as belonging to any one service, it would seem to me that you could ensure the kind of assistance that individual needs.

[COMMITTEE NOTE.—Under the DHA the surgeons general would maintain their authority in field facilities. Situations concerning fixed-site facilites, or activities involving all the services, would be handled by the DHA office. Cross-service questions would fall to the one entity and expedite their resolution.]

Mr. REGULA. Going to the example in Grenada, this was a mobilization situation and, yet, because of interservice differences, the Army helicopters with wounded could not land on the Navy ship where they needed the treatment. Finally, they were able to get Navy helicopters to carry those individuals, but in the meantime, there was a loss of time. In a different situation this could have been translated into lives.

Today, we have more sophisticated medicine. You have the availability of CAT scanners, the next step will be the NMR's, which are very expensive. Therefore, to provide the best quality care, I think a consolidated system which would be available in a peric mobilization as well as in peacetime, would best serve the neec the services. I agree that we must recognize that as far as battle-

field conditions, each service must have its own, autonomous medical system.

Mr. CARNEY. Well that is the problem that I have, trying to grasp having. If I read what you are saying, you would like to see under the present circumstances, a DOD-provided health care.

Mr. REGULA. Correct.

Mr. CARNEY. You wouldn't have blue suits or green suits or white suits——

Mr. REGULA. Right.

Mr. CARNEY. You would have a DOD system.

Mr. REGULA. Right.

Mr. CARNEY. Would those people have the types of rank, military command setup, that we are familiar with now. Would a person be an O-6 and an E-5, and that type of thing?

[COMMITTEE NOTE.—The rank of the participating officer would remain the same as in his, or her, respected service. A system could be implemented which would permit DOD to recommend rank advancements to the service. But it would be the responsibility of the service to act upon the recommendation. Also, this situation would only exist in fixed facilities and not the field facilities still under the service's jurisdiction.]

Mr. REGULA. Furthermore, I think the health care system in a reorganization would, eliminate duplication of hospitals. And just here, in the Nation's Capital, or in this immediate area, you have few availabilities. You have Walter Reed and, of course, Bethesda. And, if there were a consolidated service, perhaps each of those facilities would specialize in providing the kind of care that the serviceperson needs, but not duplicate.

And, obviously——

Mr. CARNEY. But you are speaking of tertiary care.

Mr. REGULA. That's right. The individual that would come out of the battlefield would go to the facility best equipped to meet the needs of that person. That would be a DOD facility rather than an Army, Navy or Air Force facility.

Mr. CARNEY. I appreciate what you are saying, but I feel uncomfortable with dealing with a colleague right now and I do not mean to be——

Mr. REGULA. I understand. You are challenging the structural way in which this could be achieved.

Mr. CARNEY. Right. And I am looking for the answers, just as you are. I am motivated the same way you are. But, if you take, for instance, the fact that we say, or statistics will show, that the present hospital census is only 50 percent full, I do not know if you can do that when you look at the Washington area. I would suggest that both Walter Reed and Bethesda Naval Hospital have a census of 95 to 100 percent, almost continually. They provide the tertiary-type care that absorb people from other institutions within the system, where they do not have the availability of open heart surgery teams and that type of thing, renal dialysis, whatever the case may be.

You are, let us say at Walton Army Hospital at Fort Dix, and you are in need of that, you would come to either/or hospital. But that one particular Army hospital at Fort Dix might be at 50 percent, I do not know. And that might be at 50 percent, because that

is a basic training area, and there is a certain flexibility you have to have for mobilization. You have to have those beds if you are going to be training three or four divisions of troops at one time, but now we are only training maybe a half division.

I just do not know how it can be done. Another problem that I see too, that we have not addressed, and I am sure that you were looking at, is the types of mobilization that we are talking about in another area, not the continental United States. What I really have a great deal of concern about is we do not have the tents, and we do not have the beds, and we do not have the professionals to mobilize. It is just such a difficult situation. There is so much to be done.

I think, maybe, what I am saying is, when you say 50 percent, you have to be a little bit careful. We need that expansion capability.

Mr. REGULA. You're talking about a surge capacity that would be required in the event of mobilization, because the influx of people needing care would be much greater.

Mr. CARNEY. Yes.

Mr. REGULA. And therefore, you need that redundancy.

Mr. CARNEY. And it's the type of thing where, you know, when you are getting into bricks and mortar, you just cannot build a hospital in 6 months' time. It is rather difficult. That is when the health care would really get bad.

Mr. REGULA. Well I think that you are challenging, and correctly so, the structural problems that would result from trying to consolidate services. That's a traditional argument against consolidation. I do not think it would be easy. We have been through many years of saying that we were going to have the same airplane for all three services, and that did not work very well. I have no illusions that this would be accomplished easily. On the other hand, I think that if we would examine the entire health care capacity of the services, we would find, even given your mobilization concern, that there is an excess. When you have that kind of a situation it is not very cost effective. I am simply saying, let us examine the situation and see if, perhaps——

Mr. CARNEY. I agree.

Mr. REGULA [continuing]. We can achieve greater efficiencies while improving the level of care.

Mr. CARNEY. I agree 100 percent with that. I think we have to be a little careful when you talk about hospitals and military atmosphere. You have isolated areas that we use for good reason. You cannot fire a 105 howitzer down Main Street, Smith Town. So, maybe at Fort Hood where you can fire them, or Fort Irwin, CA, where you can fire them, you go in and you find that facility has a census of 20 percent or 30 percent of its capacity. I think Fort Irwin is a good example. It has about, I believe, a 40-bed hospital out there, and you can go in at any given time and find 5 or 6 patients; but if a round—were there live fire in tank training—if a round were to go astray, we might need 30 beds in a hurry, and we might need some very capable people there. It is difficult and I appreciate your frustration.

[COMMITTEE NOTE.—Mismanagement and duplication must be eliminated to an acceptable level while preserving the military capacity to provide adequate care during mobilization.]

Mr. NICHOLS. Any other questions?

Thank you, Mr. Regula.

Mr. REGULA. Thank you very much.

Mr. NICHOLS. Mr. Regula, you may sit on the majority or minority side, wherever you like.

Dr. Mayer, you have a prepared statement, I believe.

Dr. MAYER. I do, sir.

Mr. NICHOLS. Without objection the statement will be inserted in the record of the subcommittee.

Dr. MAYER. Thank you, sir.

Mr. NICHOLS. You may proceed.

STATEMENT OF HON. WILLIAM MAYER, M.D., ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS)

Dr. MAYER. I will in that instance, Mr. Chairman, abbreviate the statement, but I would like to make several of the points.

Mr. NICHOLS. Thank you.

Dr. MAYER. First of all, I want to thank you very much for this opportunity, for this hearing, and even more for your continued compassionate and informed interest and support for military health care and for the welfare of our troops.

Mr. NICHOLS. If I might interrupt you, sir, I am here because of some mighty good military health care I received in World War II. I have never forgotten that. I appreciate paying back just a little of what I owe to the military medics.

Dr. MAYER. Thank you. You are an example of the reason that all of us who have served in military medicine, have great pride in having been associated with such a splendid system. We are also very grateful to you, Mr. Carney, Mr. Regula, and Mr. McCloskey, for your interest in this subject, which we consider to be of enormous importance. We realize that health care only occupies about 3 percent of the huge Department of Defense budget, but it is, in some ways, if you will forgive parochialism, the most critical, the most important thing that we do. The most important aspect of our defense system are the men and women who are in it. So I am very pleased to have this opportunity to appear before you here today, and discuss our efforts, particularly in the areas of medical readiness and quality assurance.

MEDICAL READINESS OVERVIEW

Concerning medical readiness, last year Secretary Weinberger ordered extensive field reviews of our overall medical readiness capability, both in Europe and in the Pacific Command. A special review group conducted a thorough investigation into areas of medical evacuation, medical command and control, medical communications, and medical planning. These reviews constituted the most extensive analysis of medical readiness that has ever been conducted, and resulted in a great deal of attention being focused on the need to improve cross-service medical planning, and increase the resources available to support medical readiness requirements.

The European and Pacific reviews contained nearly 100 specific recommendations for corrective action. These were directed at all levels within the command structure, the services, the offices of the Joint Chiefs of Staff, and the Office of the Secretary of Defense. The vast majority of these recommendations have been acted upon, many of them to completion.

One tangible result of the reviews has been a significant increase in resources committed by the leadership in the Pentagon to procuring deployable medical systems. This year's budget request contains over $500 million in various appropriations for this purpose.

In addition, we have successfully directed the reallocation of nearly $2 billion programmed between now and fiscal year 1990 to support the medical readiness effort, and expect to be at our full requirement level by that time. However, I have to confess to a very serious concern. We have managed to garner interest and support on the part of the Pentagon staff—in all the services and in the Department of Defense proper—for the need to improve our readiness situation. Yet, I learn now that the Military Construction Subcommittee of the Appropriations Committee has cut out every single medical readiness military construction project overseas that we have planned and that the Pentagon has approved and incorporated into the budget. These include some that are absolutely crucial if we are to properly provide health care to our soldiers who are deployed, and who are deployed right now.

The dollars that we have reallocated will fund not only the deployable equipment that we need, but also the people as well as the facilities and the supplies and the other support costs associated with deployable medical systems. We are also actively seeking to relocate stored mobilization hospitals at or near their intended deployment sites and have them in a turnkey- or standby-mode. This is particularly critical when you consider the enormous amount of airlift that is required to transport even just one field hospital.

During Reforger exercises, this past fall, the annual return of forces to Germany, I witnessed several of these facilities in action, staffed with both active and reserve components, flown over from the United States. I was immensely impressed by the fact that our peacetime medical force was gaining valuable training, while at the same time maintaining the operational readiness of the deployed medical assets.

HOSPITAL SHIP PROGRAM

Another element of our medical readiness program, of which we can all be very proud, is the hospital ship program. Two *San Clemente* class carriers—second in size, in the entire Navy, only to the *Nimitz*—are being converted into floating general surgical hospitals, with 1,000 beds each, an enormous helicopter landing capability, and 12 operating rooms on each ship. The U.S.N.S. *Mercy,* the first of these ships, is now in the San Diego Shipyard with conversion very well underway, and conversion of the U.S.N.S. *Comfort,* whose hull lies alongside the *Mercy,* is scheduled to begin soon.

We have also increased our efforts in obtaining host-nation support, not only in the area of land and facilities, but also making arrangements for interim assistance in hands—on medical care

until our deployable facilities become operational, and for patient transportation assistance.

Concerning aeromedical evacuation, the Military Airlift Command is now working very closely with the European Command in order to determine the extent of their medical requirements in Europe. MAC is seeking ways to increase the number of patients a C–141 can carry, re-examining the flying routes and the timetables, showing when patients may be transported, and exploring the feasibility of dedicating additional aircraft to aeromedical evacuation.

Medical communication, in a contingency, is a potential problem that we have to deal with. Each of the services has somewhat different methods of communication between command, units, aircraft, and vessels. Our medical personnel often cannot readily communicate across services' lines, due to differences in equipment and procedures. I do not yet know the full extent of this communications problem, but I plan to examine it and explore the feasibility of a dedicated medical communications capability.

The European Command—particularly supported by General Dick Lawson, who has been very much interested in medical readiness—the European Command working with my staff, is examining the feasibility of establishing a single, integrated medical logistics support system in Europe. This concept was recommended by the European Command review that I mentioned earlier. I intend to examine their findings carefully, and to make a decision on this issue as soon as they are available.

Our equipment standardization efforts have borne fruit and remain fully on track. Currently, we are developing plans which will ensure that modules for our deployable systems are properly stored to meet mission requirements and to satisfy maintenance functions.

Again, the cut in medical military construction overseas which is a relatively small amount of money in today's terms, about $36 million, means that we are going to be producing medical equipment for deployment overseas, and have no place to put it. Most of that construction is for warehousing, hard-stand, places to have that stuff ready to go, if we need use it, and even use it right on site.

While I am pleased with the significant steps that we have taken, and I think they really are significant, there are other problem areas in which satisfactory progress clearly has not yet been made. Primarily, I am concerned that only small gains have been made in integrated cross-service medical readiness planning, although it is progressing. And, by the differences among the service's methods for predicting wartime medical manpower requirements, and the fact that a full-time flag officer or general officer has not been designated as the European Command Surgeon.

It is that job which is an additional duty for the senior military surgeon in Europe, currently Dr. William Greendyke, who is a major general in the Air Force. That task of European Command Surgeon occupies fully half his time, and he tells me it could very well occupy all of it. But, his Air Force duties require the other half of his time, and we very badly need to proceed with putting a general officer, full time, in charge of all medical activities in that unified command, as well as in the Pacific.

MANPOWER REQUIREMENTS

With respect to manpower requirements, the development of a common methodology for predicting wartime requirements for medical manpower has been a very high priority of mine for some time, and I am pleased to say we are finally approaching a solution. In the past, each of the services used fundamentally different methods to estimate the manpower required to perform a different workload.

For example, to staff 1,000 beds in the continental United States, the Army predicted it would require 106 physicians; the Air Force, 166; and the Navy, 392. These disparities are being reconciled now, to permit the development of effective mobilization plans and balance manpower programs. And those disparities could be readily understandable, given the different needs of the services, and the methods which have grown up over the years to determine requirements, but they clearly could not be supported if we were talking about the same kind of a 1,000-bed hospital in the continental United States.

It is critical that manpower allocation decisions be made on the basis of their contribution to wartime readiness. To the extent practicable, I intend to apply this policy during our upcoming review of the services' budget which, on the part of Health Affairs, will be far more searching in detail than ever before in our review of their budgets for the fiscal year 1987.

The recently completed report of the blue ribbon panel on sizing of DOD medical treatment facilities also recognized the overriding importance of medical readiness. One of the panel's principal recommendations was that medical readiness be the primary criterion for determining the size and composition of the entire peacetime active duty medical force, and of all facilities and workloads in our direct care system.

Secretary Weinberger has fully endorsed the blue ribbon panel's recommendations and we, in Health Affairs, and in the services, are moving to implement all of its recommendations without delay. This implementation will result in, for the first time, coordinated and centralized management of all military medical construction and design.

QUALITY OF CARE

Now, if I may, a word about quality of care. I remain convinced that the overall quality of care in military medicine is equal to, if not better than, care overall in the civilian sector, despite the relatively small number of highly visible, very real, tragic instances, which have received the recent public attention. Since coming to the Department almost 2 years ago, I have forcefully carried out the strong commitment to quality health care made by Secretary Weinberger early on in this administration. We have issued numerous directives covering a broad spectrum of quality assurance measures. Some of the more recent directives deal with the licensing of military health care personnel, administration of clinical investigations, and restricting off-duty employment of military health care providers.

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The licensing directive signed on July 18 requires that military physicians, nurses, dentists and clinical psychologists, have exactly the same State licenses demanded of their civilian counterparts.

I have also decided to adopt a program of external civilian peer review of military hospitals worldwide. Not to replace our own efforts at all, but to supplement the existing DOD quality assurance program, which, I believe, is today miles ahead of anything else that exists in the civilian community at this point, and to review the appropriateness of care in our medical treatment facilities. It will actually serve as a monitor of the effectiveness of our own internal quality assurance efforts.

A request for proposals has been developed and a civilian contractor will begin work in January 1986.

CONCLUSION

In conclusion, Mr. Chairman, since coming to the Department some 2 years ago, I have devoted my energies to three things. Improving the readiness of our medical system, the quality of care that it provides in wartime and peacetime, and the cost effectiveness of the entire system. We have made progress, real progress, in all three areas, though much more remains to be accomplished. One thing that has become clear to me is that our reliance on our direct care system to accomplish both our wartime readiness and our mandated peacetime benefit mission has placed significant strains on our ability to accomplish either one of those missions effectively. Pressed by a demand to provide comprehensive health care to some 10 million beneficiaries, we have not been able to assure top priority to wartime readiness until now.

Thus, our force structure does not meet our wartime requirements either in number or in mix. Our training programs fail to adequately address these specific manpower priorities. Our peacetime benefit mission represents a workload that is very often largely irrelevant to developing and maintaining the specialty skills that are needed for wartime readiness.

And, finally, our civilian care services, such as CHAMPUS, are too costly and do not take sufficient advantage of the competition in the civilian health care marketplace that is developing around the country.

I believe our greatest challenges during the next several years are first to sort out our wartime readiness mission, and our peacetime benefit mission; second, to improve substantially our ability to utilize civilian health care resources to meet a larger portion of our peacetime benefit demand; and, third, to accelerate the redirection of our military direct care system, to effectuate our top priority commitment to medical readiness.

Meeting these challenges will likely require some departures from traditional methods of operation, if not massive reorganizations. If so, we will have to be ready to make such departures. Medical readiness is, of course, our reason for being, and I assure you, Mr. Chairman, my attention and those of my colleagues in this area will not falter. It is the very least we owe to those who risk life and limb in combat to defend this Nation. Thank you, sir. That completes my statement.

[Statement of Dr. Mayer follows:]

PREPARED STATEMENT OF HON. WILLIAM MAYER

Mr. Chairman, members of the subcommittee: I am pleased to have this opportunity to appear before you today to discuss the Department of Defense's efforts in the area of medical readiness and quality assurance. I would like to begin today with a brief overview of the size and scope of the Department's medical activities in order to provide a framework within which to examine our efforts.

OVERVIEW

The fiscal year 1986 budget request for military medical operations is over $9.6 billion. This includes approximately $3.4 billion for the Army, $2.1 billion for the Navy, and $2.5 billion for the Air Force. Also included is nearly $1.5 billion for CHAMPUS, and $97 million for Medical Information Systems.

Nine point six billion dollars is an impressive sum of money, and the medical system which these dollars support is equally impressive. We operate over 500 facilities, worldwide, including 168 hospitals. These are staffed by over 170,000 physicians, nurses, administrators, medical corpsmen and other support personnel. On any given day, some 23,500 beneficiaries will be inpatients in these hospitals or under CHAMPUS and during the course of the year we will provide over 56 million outpatient treatments, and process more than 5 million claims from civilian providers.

The vast majority of our budget request goes to support our enormous day to day responsibilities for health care for nearly ten million people. This peacetime activity does, of course, play an important role in supporting our readiness mission. In addition, this year our request includes over half a billion dollars dedicated solely to improving our medical readiness posture. This represents a sizeable increase over previous requests.

MEDICAL READINESS OVERVIEW

Last year, Secretary Weinberger ordered extensive field reviews of our overall medical readiness capability, both in Europe and the Pacific. A special review group conducted a through investigation into the areas of medical evacuation, medical command and control, medical communications, and medical planning.

These reviews constituted the most extensive analysis of medical readiness ever conducted and resulted in a great deal of attention being focused on the need to improve cross-service medical readiness planning and increase the resources available to support medical readiness requirements. The European and Pacific reviews contained nearly 100 specific recommendations for corrective action. These were directed at all levels within the command structure, the Services, the Office of the Joint Chiefs of Staff, and the Office of the Secretary of Defense. The vast majority of these recommendations have been acted upon, and a number of offices and individuals, particularly in the commands, deserve credit for their efforts.

DEPLOYABLE MEDICAL SYSTEMS

One tangible result of these reviews is a significant increase in resources committed to procuring deployable medical systems. As I mentioned earlier, this year's budget request contains over $500 million in various appropriations for this purpose. In addition, we have successfully directed the reallocation of nearly two billion dollars programed between now and Fiscal Year 1990 to support the medical readiness effort and expect to be at our full requirement level by that time. These dollars will fund not only the deployable equipment we need, but also the people, facilities, supplies, and other support costs associated with deployable medical systems.

I recognize, though, that items programmed for 1990 provide no help today, and so we have taken a number of steps to make what is or will soon be on hand more accessible. We are actively seeking to relocate stored mobilization hospitals at or near their intended deployment sites and have them in a turnkey or standby mode. This is especially critical when one considers the tremendous number of aircraft needed to transport just one of these hospitals. During REFORGER exercises this past Fall, I witnessed several of these facilities in action, staffed by both active and reserve components flown over from the United States, and was impressed by the fact that our peacetime medical force was gaining valuable training while at the same time maintaining the operational readiness of deployed medical assets.

HOSPITAL SHIP PROGRAM

Another element of our medical readiness program of which we can all be proud is the hospital ship program. Two San Clemente-class tankers are presently being converted into floating general hospitals with 1,000 beds and 12 operating rooms each. The USNS MERCY is now in San Diego shipyard with conversion well underway and conversion of the USNS COMFORT is scheduled to begin soon.

HOST NATION SUPPORT

We have also increased our efforts at obtaining host nation support, not only in the area of land and facilities, but also making arrangements for interim assistance in hands-on medical care until our deployable facilities become operational and for patient transportation assistance, such as dedicated hospital trains. While the exact nature of these support agreements and the parties involved are classified, I can say that we have made substantial progress over the past two years at establishing new arrangements and clarifying existing ones.

AEROMEDICAL EVACUATION CAPABILITY

The Military Airlift Command is working more closely with the European Command to determine the extent of their medical requirements and how MAC can best serve them. MAC is seeking ways to increase the number of patients a C-141 will carry; reexamining the flying routes and time tables showing when patients may be transported; and, exploring the feasibility of dedicating additional aircraft to aeromedical evacuation. In November of this year, an interim automated patient evacuation system should be operational to better assimilate the massive patient data which flows in on a daily basis.

COMMUNICATIONS

Each of the Services has methods of communication between Commands, units, aircraft, and vessels. The means of communication vary from land lines to satellites and vary from Service to Service. Our medical personnel often cannot communicate across Service lines due to differences in equipment and procedures. I do not yet know the full extent of this communications problem, but I plan to examine it and explore the feasibility of a dedicated medical communications capability.

The European Command, working with my staff, is examing the feasibility of establishing a single, integrated medical logistics system in Europe. Such a concept was recommended by the European Command Review I mentioned earlier. I intend to examine their findings carefully and make a decision on this issue as soon as they are available. Our equipment standarization efforts remain on track. Currently, we are developing plans which will insure that modules for our deployable systems are properly stored to meet mission requirements and to satisfy maintenance functions.

While I am pleased with these significant steps, there are other problem areas in which satisfactory progress has not been made. Primarily, I am concerned that only small gains have been made in integrated, cross-service medical readiness planning, and by the differences among the Services' methods of predicting wartime medical manpower requirements.

MEDICAL READINESS PLANNING

More than a year and a half ago, the report accompanying the review of medical readiness in the European Command contained a number of specific recommendations regarding planning activities. These included: providing adequate medical planning staffs; reconciling inconsistencies in planning and procedures for the control and use of the aeromedical evacuation system in wartime; establishing joint command and control over medical planning and medical resources; directing joint utilization of medical resources in wartime; and developing joint medical plans for dealing with terrorist attacks. This past Spring, the U.S. European Command held a conference on medical planning to address many of the recommendations cited by the review group. I attended that conference and was pleased that it resulted in the identification of six major objectives to partially address the problems outlined in the report. Although a great deal of discussion has taken place in this area over the past year and a half, to date few definitive actions have been taken.

I do not consider this rate of progress acceptable, but must admit that I have not been very successful in altering it. To a large extent our problems stem from much larger issues dealing with how the Unified Commands relate to the individual Serv-

ices and how the Office of the Secretary of Defense, in general, and the Assistant Secretary for Health Affairs, in particular, relate to the Military Departments. To address the issue of how the unified commands relate to the individual Services, I have recommended strongly with Secretary Weinberger's support that the Command Surgeon in Europe be a full-time flag officer with clear authority to review and oversee joint medical planning for all three Services. Regarding the relationship between my office and the Services, Secretary Weinberger has recently delegated to the Assistant Secretary for Health Affairs the authority to serve as program manager for all DoD health and medical resources. I am confident that this will facilitate our progress.

PREDICTING MANPOWER REQUIREMENTS

Development of a common methodology for predicting wartime requirements for medical manpower has been a priority of mine for some time and, I am pleased to say, we are finally approaching a resolution. In the past, each of the Services used fundamentally different methods to estimate the manpower required to perform a given workload. For example, to staff 1,000 wartime hospital beds in the United States, the Army predicted it would require 106 physicians, the Air Force 166, and the Navy 392. These disparities could not be adequately reconciled to permit the development of either effective mobilization plans or balanced manpower programs.

The obvious problems generated by these differences have been recognized since 1978 yet have proven extremely difficult to rectify. However, efforts to design a standardized, workload-based methodology for predicting requirements have been productive and have resulted in the development of a computerized model, the Medical Planning Module (MPM) of the Joint Operation Planning System (JOPS). Some improvements are required in the data base before it will be capable of predicting the full range of wartime medical requirements, but it clearly contains the correct logic for making those predictions.

To correct this situation, I have directed that the necessary additions be made to the Medical Planning Module (MPM) data base and that all three Services utilize it in developing future requirement submissions. This policy is now in force.

It is critical that manpower allocation decisions be made on the basis of their contribution to wartime readiness. I intend to direct the Services to develop peacetime medical force structures that are as close as possible to wartime requirements. This will include all facets of the force structure development process to include total force specialty mix, all training programs, recruiting and retention efforts and other accession plans. To the extent practicable, I intend to apply this policy during our upcoming review of the Service budgets for Fiscal Year 1987.

BLUE RIBBON PANEL ON SIZING

The recently completed Report of the Blue Ribbon Panel on Sizing DoD Medical Treatment Facilities also recognized the overriding importance of medical readiness. One of the Panel's principal recommendations was that medical readiness be the primary criterion for determining the size and composition of the entire peacetime active duty medical force and of all facilities and workload in our direct care system. The Panel also advocated the establishment of firm guidelines to ensure that future facilities planning efforts be consistent with our readiness mission. Secretary Weinberger has fully endorsed the Blue Ribbon Panel's recommendations and we in Health Affairs are moving to implement all of its recommendations without delay. This implementation will result in, for the first time, coordinated and centralized management of all military medical construction and design.

QUALITY OF CARE

I would like to turn now from our medical readiness mission to another area of great concern—not only to the Department and this Subcommittee—but to every one of our 10 million beneficiaries. This is our all-consuming effort to provide high quality health care in our military medical treatment facilities. Unfortunately, recent media coverage of military medicine has focused on several incidents in which medical treatment problems have occurred—as they do in every medical center, no matter how excellent. These selected incidents have been used to imply that most military medical care is not quality care.

I remain convinced that overall quality of care in military medicine is equal to, if not better than, care overall in the civilian sector, despite the relatively small number of highly visible tragic instances which have received the recent publicity. As with our medical readiness capability, there is always room for improvement.

Our efforts to improve the quality of the care delivered in all of our facilities continue.

Since coming to the Department almost two years ago, I have forcefully carried on the strong commitment to quality health care made by Secretary Weinberger early on in this Administration. We have issued numerous directives covering a broad spectrum of quality assurance measures. Some of the more recent directives deal with licensing of military health care personnel, administration of clinical investigations, and restricting off-duty employment of military health care providers.

The licensure directive, signed on July 18, requires that military physicians, nurses, dentists, and clinical psychologists have exactly the same State licenses demanded of their civilian counterparts.

A directive to be issued this month on clinical investigations is aimed at preventing conflict of interest when non-DoD funds are made available for clinical investigation services.

Finally, a second directive to be issued this month relating to off-duty employment is expected to limit the demands placed on our military physicians in their off-duty hours and thus promote a more rested and capable provider in our military facilities.

However, I am very much aware that plans are not results and that policy statements alone do not assure quality. We are also looking to new and innovative techniques to directly impact upon the military medical system. Our most recent example is the unprecedented decision to adopt a program of external civilian peer review of military hospitals worldwide. This system of Professional Review Organizations (PRO's) will supplement the existing DoD quality assurance program by providing for independent review of the quality and appropriateness of care in our Medical Treatment Facilities (MTF's) and will actually serve as a monitor of the effectiveness of our internal quality assurance efforts. We see the creation of this civilian/military partnership for military medical excellence as a giant step forward to build credibility and confidence in the quality of military health care and to ensure our quality of care is, indeed, the very best possible.

After much deliberation and consultation on this very ambitious effort, we are now well on our way toward the goal of having the PRO system in place early in 1986. A Request For Proposal has been developed and a civilian contractor will be selected this Fall. The contractor will be responsible for performing peer review of medical care in all inpatient MTFs and in the Uniformed Services Treatment Facilities starting in January 1986.

CONCLUSION

Mr. Chairman, since coming to the Department some two years ago, I have devoted my energies to three things: improving the readiness of our medical system, the quality of care it provides in wartime and peacetime, and the cost-effectiveness of the entire system. We have made progress in all three areas, though much more remains to be accomplished. One thing that has become clear to me is that our reliance on our direct care system to accomplish both our wartime readiness and peacetime benefit mission has placed significant strains on our ability to accomplish either effectively.

Pressed by a demand to provide comprehensive health care to some 10 million beneficiaries, we have not been able to assure top priority to wartime readiness. Thus, our force structure does not meet our wartime requirements either in number or mix. Our training programs fail to adequately address these manpower priorities. Our peacetime benefit mission presents a workload largely irrelevant to developing and maintaining specialty skills necessary for wartime readiness. And, finally, our civilian care services such as CHAMPUS are too costly and do not take sufficient advantage of competition in the civilian health care marketplace.

I believe our greatest challenges during the next several years are: first, to sort out our wartime readiness mission and our peacetime benefit mission; second, to improve substantially our ability to utilize civilian health care resources to meet a larger portion of our peacetime benefit demand; and third, to accelerate the redirection of our military direct care system to effectuate our top-priority commitment to medical readiness. Meeting these challenges will likely require some departures from traditional methods of operation. If so, we will have to be ready to make such departures.

Medical readiness is, of course, our reason for being and I assure you, Mr. Chairman, that my attention and efforts in this area will not falter. It is the very least we owe to those who risk life and limb in combat to defend this nation.

Mr. NICHOLS. Thank you.

I have some hesitation to bring up an issue that has been aired at great length, relating to care of casualties at Lebanon; but, since this subcommittee wrote the report for the Congress on that matter, and since Admiral Long's committee did some investigating into the same matter, let me bring to your attention a couple of documents that have come to the committee, and ask you to comment on them, if you would, sir.

I have here a document by Brig. Gen. Richard Hansen, USAF. I have another document from Colonel Ward, an Army Doctor. In looking at both of these allegations, it comes to my mind that there may have been more on the minds of military personnel in that debacle than just attending to the needs of the casualties. For example, according to Colonel Ward, and listen to me carefully, if you will, sir.

According to Colonel Ward, Air Force officers told the Army medics to, and I quote, "refrain from any contact with the press, and that press releases would be coordinated, through the Air Force."

According to Colonel Ward, Air Force assumed control of patient distribution, and he says it was very obvious from the manner in which the Air Force triage team was working, the goal was to maximally triage, which, in civilian lingo, means send patients to Wiesbaden, despite Ward's protests that the Army facilities were closer in some cases and in other cases were better equipped to handle the given injury.

According to Colonel Ward, he told the Air Force official that he did not think this distribution could be defended, medically, morally, or ethically.

According to General Hansen, despite the fact that the European Medical Command structure is inadequate, he says, and I quote:

> There will be enormous resistance by all three services and their Surgeons General to any degree of directive authority on the super-service level that impinges on present service-unique prerogatives to decide wartime concepts and how funds should be spent for medical supplies and facilities.

I guess my question to you is, do you know whether General Hansen was aware at this time of the number of available surgeons and operating rooms and Army hospitals before he decided to direct evacuation aircraft to Rhein Main, rather than to Ramstein?

My second question is, do you know whether any Air Force medical officers obtained such a report before that decision?

Dr. MAYER. With respect to the first question, sir, I think General Hansen had——

Mr. NICHOLS. We are rehashing old issues here.

Dr. MAYER. Yes, I understand.

Mr. NICHOLS. I guess if we do not learn from experience, then we are in bad shape. May I just ask you to comment on that.

CARE OF CASUALTIES IN LEBANON

Dr. MAYER. I think General Hansen has a reasonably accurate idea of the number of surgeons that were available in the various hospitals in the Army—in Europe. And, of course, the Army runs most of the hospitals in Europe. Whether he had a sufficient level of detail knowledge to influence him significantly, I do not honestly

know. I do know that "Hap," as we called him, was well aware of the capabilities at Wiesbaden, had great confidence in them, and I do not think his actions were based on a competitive thing with the Army, so much as a kind of a parochial loyalty, he felt that Wiesbaden would be adequate for the patients to go there.

That, as in many complicated decisionmaking processes, people of approximately equal intelligence and certainly good will and the same objectives in mind, will differ very significantly on how to accomplish their tasks. On hindsight, it seemed to many people that probably it would have been best to send that airplane on to Ramstein instead of Rhein Main, because it was closer to what is, unquestionably, the most elaborate, biggest, best equipped, and best staffed military hospital in Europe.

But, I would like to emphasize that neither as a result of General Hansen's decision, nor of any of the other kind of expectable confusions that confound activities in such a disaster, nothing that the services did, from the splendid care that started with dentists in the Navy and continued with young doctors aboard their ship, through the process of evacuation, through the hospitalization, even the rehandling that became necessary, as patients did have to get sent by chopper from Rhein Main on to Landstuhl where they should have gone in the first place—none of that, in any way, worked to the detriment of any of those patients. The potential was there for doing harm, but no patient was harmed.

Mr. NICHOLS. Let me make it abundantly clear that I am not making that allegation.

Dr. MAYER. I understand, yes, sir.

Mr. NICHOLS. In any way, shape or fashion or form. And I understand those loyalties. They were born on the playing fields of West Point, and Annapolis, and Colorado Springs, and a man ought to have pride in his branch of service. I understand those. But I read further in Colonel Ward's letter here. He says, Air Force triage teams admitted that they only had one orthopedic surgeon at Wiesbaden, whereas they had six at Landstuhl, seven at Frankfurt, and five at Nuremburg, it looks like.

Mr. Carney, do you have a question?

Mr. CARNEY. Mr. Chairman, I do not know if you want to continue to pursue that. If you would, I will yield to you.

Mr. NICHOLS. No. My time is up. Go ahead, sir.

Mr. CARNEY. Thank you. I would like to swing from that to a couple of other topics, if I may, particularly my concern for the Appropriations Committee deleting the bricks and mortar for advance positioning of emergency or mobile hospital equipment.

What impact is that going to have now? Where will that equipment that was supposed to be pre-positioned there be? Will it be back in the continental United States?

PRE-POSITIONING OF MEDICAL FACILITIES

Dr. MAYER. Yes, sir. I should explain that when we order such a complex set of items as that necessary to equip a field hospital, that it takes up to 2 years for that gear to be procured and assembled, packed and shipped. Now, the Defense Logistics Agency and our own logistical systems have proceeded very rapidly to procure

the equipment that we need. And, as I mentioned, we standardized. It is in the process of being assembled and brought together.

Now, even here in the United States, there is no place to store that stuff once we get—at least currently in hand, we will have to go out and hire warehouses or something—but it does not do us any good to pack a 500-bed field hospital in this country when we might, on a very short notice, a matter of days, need that thousands of miles away, and have to carry it by using a number of C-141's which, in an emergency, are not going to be available, reasonably, to transport medical equipment.

The most important case in point that I would like to make, has to do with a hospital site, it is really a warehousing site, but it can be—hospitals can be put into effect right in this warehouse, situated by the international airport outside of Pusan in South Korea. The number of beds we have available to support the—I do not think it is a classified number at all—the troops that we have in Korea, the number of beds that we have today there—they are very good beds, they are old—the total is only 140 approximately, and that can be expanded to perhaps, 300.

At Kim Hae, down by Pusan, the Air Force was in the process—of land acquisition it has been designed. The Korean Government has cooperated, we are going to put a 500-bed field hospital and adjoining it a 250-bed aeromedical staging facility, next to an international airport, far from the DMZ, in a country where we have a large number of young Americans ready to go to war, not after 2 or 3 months preparation, but they might have to go to war with 24 hours notice. And we know that capability exists on the part of the North Koreans.

What it means when that basic construction, and as I say, it is not terribly expensive, we are not building Walter Reed over there, we are building some concrete platforms and some good shelters where we can store this equipment, but where we can break it out and use it if necessary, right on the spot. A bigger capability than the entire capability we have at present in Korea, when that is scratched from the budget, and I have to admit, some stateside construction was scratched, too, but we are concerned with readiness, and when that is scratched from the budget, it means another year's delay before that can proceed. More negotiations with the Korean Government—because they let the people farm right up to the last minute, your land is precious there.

And, so, we have just been set back again, in keeping with a thing that used to happen in the Pentagon and which we finally got corrected, and that is that budgeted items, beyond the immediate budget year and the 5-year defense plan, kept getting slipped. And that is a nice word. But it just means, you do not do it. You put it off until next year and next year and next year. And the result is that we have not gotten it built.

Mr. CARNEY. Is it my understanding you are saying that you have 125 beds in Korea?

Dr. MAYER. Well, we have about 145 beds.

Mr. CARNEY. Total?

Dr. MAYER. Yes; in essence, yes. Now, we have, within the Second Infantry Division, we also have the normal battalion aid stations, but we do not have——

Mr. CARNEY. You do not have evacuation hospital capability or a field hospital capability right now in Korea?

Dr. MAYER. Yes, sir; we have one, 145 beds.

Mr. CARNEY. That was in Seoul. That is either an evacuation or a field hospital. What is that?

Dr. MAYER. Well, it is called Seoul Community Hospital. It is really the 121st Evacuation Hospital. It is expandable.

Mr. CARNEY. Are bricks and mortar there?

Dr. MAYER. Not exactly bricks and mortar. There is some stucco and wood. But it is old and needs work, there is no question about that.

Mr. CARNEY. And how many beds are there?

Dr. MAYER. About 140, 145, but across the street and down a block or so, there is a school that we can use to increase the bed capacity by a couple of hundred more.

Mr. CARNEY. Do I assume that medical care for the troops now is being taken care of in Japan, maybe.

Dr. MAYER. No, sir; it is being taken care of very adequately in Korea, with the exception of those very highly specialized neurosurgical procedures or cardio-thoracic surgery, and our medical evacuation system which the Air Force operates there, makes it possible to take that kind of work to Clark Air Force Base in the Philippines or to Okinawa or to Japan.

Mr. CARNEY. Mr. Chairman, I heard the bell. But, could I have just 2 more minutes?

Mr. NICHOLS. Without objection.

Mr. CARNEY. Thank you. I want to make sure I have this straight. You are saying you have 145 beds in Korea.

Dr. MAYER. Yes, sir.

Mr. CARNEY. Well, what is your expansion capability right now?

Dr. MAYER. About 300 more beds, plus the Air Force is building a very fine hospital a few miles south of Seoul that we think is a very excellent advanced design. It has 40 beds.

Mr. CARNEY. Well, that is to take care of your medical needs today.

Dr. MAYER. Yes, sir.

Mr. CARNEY. Given nothing should happen in Korea.

Dr. MAYER. That is correct.

Mr. CARNEY. So you have 145, plus 40, which would be of a bricks and mortar-type of permanent facility that the Air Force would run.

Dr. MAYER. Yes; 40 when completed there.

Mr. CARNEY. And you have an expansion capability of what?

Dr. MAYER. About 300 more.

Mr. CARNEY. About 300 more?

Dr. MAYER. Yes, sir.

Mr. CARNEY. I am shocked at that.

Dr. MAYER. So am I. I am also shocked at our inability, once we fought a good battle in the Pentagon, and got tremendous support from the line and from the DOD officials to get the money——

Mr. CARNEY. Can you answer me one other question? Do we have any agreements to take care of the medical requirements of South Korean military personnel in time of conflict?

Dr. MAYER. Do we have requirements or agreements?

Mr. CARNEY. Agreements. I mean, obviously, if there was an outbreak of hostilities right now, I would think there would be an enormous short-fall of beds to take care of Americans, but we would be fighting over there shoulder-to-shoulder with South Koreans. Do we also have a responsibility, a moral obligation or a contractual responsibility, to take care of their health care needs as well?

Dr. MAYER. No, sir.

Mr. CARNEY. They are on their own?

Dr. MAYER. Yes, sir. We do not——

Mr. CARNEY. Bother with responsibility. Thank you. Thank you, Mr. Chairman.

Mr. NICHOLS. Mr. McCloskey.

Mr. MCCLOSKEY. Thank you, Mr. Chairman. I want to commend Dr. Mayer for an excellent statement. We have all heard from him before on numerous concerns in the areas in which he is working. I will probably be brief—and we had a chance to talk about this previously, Doctor—but following up on some of the chairman's concerns, I know you are improving support logistics and communications regarding emergency medical evacuations and so forth, but it has been stated, and I think quite officially from the Pentagon, that we still presently, or at least until very recently, have lacked a comprehensive program for decisionmaking in the event of terrorist-oriented or war casualties.

I know your work in this area. Could you say if something happened tonight in Central America, the Mid East or wherever, say 50 to 100 casualties, that there would be a tremendously minimized chance that we would not hear again about such problems as we heard in Germany and with the Army helicopters approaching the Navy ships and so forth?

EMERGENCY MEDICAL

Dr. MAYER. I would like to say with perfect confidence that a repetition of the kinds of confusion that we experienced in the past would not occur. I cannot say that. The reason I cannot say that is there is still no full-time Command Surgeon. Although, as I said, General Greendyke is doing a superb job as European Command Surgeon; that is an additional duty for him. And, neither in the Pacific nor in Europe, is there a plan for a designated person in charge who can give orders to each branch of the service's medical participants in such an operation.

I do not think that it would be nearly as bad as it was. I do not mean to minimize what has been done. Very good plans have been developed in Europe for responding to terrorist attacks and to repetitions of Beirut. I think that the coordination and communication would be far better. I do not think there would be the confusion as to where people went. But, still, if you have ever been in such an emergency situation, you know that the first requirement is for command, control and communication.

And that command has to be a one-headed beast, not a collection or a committee, or something that is coordinated back and forth across the communication system that is not always good.

Mr. McCLOSKEY. Could I just state, quite bluntly for the record that I would find it outrageous if this is not corrected, say, within 72 hours. Whether you are a mayor or a governor or a military officer, or a Pentagon official, charged with the safety and security of people, I suggest, Doctor, that it is time for a Gordian knot approach to name someone in all these different commands and problem areas—surely, you do not need a totally perfect plan, but Mr. Weinberger has to have someone with the authority to make those decisions. And we talked about this months ago, and you were concerned that it had not been worked on in the last year. Mr. Chairman, I would like to meet with Mr. Weinberger, say, within a week, if this is not resolved within a matter of hours.

I think it is very serious.

I would appreciate your responding to that, Mr. Secretary.

Mr. NICHOLS. Would the gentleman yield just a minute? Let me ask if I understood you. You are talking about this beast we create that has to have a firm hand. I assume what you are saying is that you have no problems with a peacetime triservice organization to handle emergencies such as we had in Lebanon that may arise again.

Would you give us your position on that in wartime?

Dr. MAYER. In wartime, it becomes obviously even more essential that we have a very clear medical command and communication structure. And it is only by putting it in place in peacetime, even if we did not have the threat which exists daily of terrorist attacks, it is essential even without that, that such a structure be in place and be functioning, the lines of authority be very clearly established.

And, I think that we have not so much received opposition to that idea. I have never had one of the services object in any way to that. I think that there is agreement in principle right up through the Joint Chiefs of Staff. It has been a problem more of general and flag officer allocations, of the specific limits on the number of such officers available, their commitment to specific jobs within the United States, and I would have to say, at the risk of engendering the antagonism of my line comrades, that we need a few more good medical general and flag officers. More than we are authorized.

Mr. McCLOSKEY. Mr. Chairman?

Mr. NICHOLS. Did you get your question?

Mr. McCLOSKEY. Mr. Chairman, if I could just reclaim my time for just one brief question. Doctor, and I am not really being antagonistic——

Dr. MAYER. Right.

Mr. McCLOSKEY. Could you state, in a simple and expeditious way what would be the problem in every area of potential conflict, every significant area? I know you can not cover the whole world, but there should be someone charged with the command responsibility in the event of emergency to disperse the medical priorities. I do not understand why that would be so difficult, even though it is not a perfect plan, which I realize—or the answer to everything, but, at least, to handle possible emergencies for the time being as you perfect your plans.

Dr. MAYER. Well, at present in Europe, we have a EUCOM Surgeon, a European Command Surgeon. As I said, he is sitting here

today—General Greendyke—and this is only half his job. And plans have been made now, and agreed upon among the three services in Europe, as to how a response would take place were there to be such a contingency situation.

The fact that this is an additional duty, without a real support staff of sufficient size, to do all the planning, and all the cross-service training that is necessary, and establish all the agreements, all the lines of communication, would make it very difficult for General Greendyke to manage, especially if more than one episode took place at one time. It is not a reflection on him or on any of the services. I do not mean to imply that the services are not abundantly capable, as they showed in Lebanon, of turning instantly, and doing their very best and saving lives.

But, we do not have the centralized authority to direct cross-service medical operations. The European Command is a unified command, the Commander in Chief in Europe commands everything that goes on there. He has the ability to order any medical unit or ordnance unit or airplane or anything else that is part of the unified command—European Command—to do as he wishes, and as he commands.

And, theoretically, that is true of the medical system, just as it is of the rest. In practice, however, the necessity is for an individual who devotes full-time to that, who has adequate staff to support him, who is of sufficient rank to be heard among the other generals and admirals who run the military operations there, and to be able to give orders which are unquestioned, whether it is directing an airplane, whether it is saying to what hospitals people are going to go, or mobilizing medical people to send them to the site. It has been a difficult task to put this into place, but the services—even in the absence of a specified full time commander—have made giant steps toward making sure that we can work together and function together.

Mr. McCLOSKEY. Mr. Chairman, maybe you and I and Dr. Mayer and anyone else interested, could meet with Mr. Weinberger very soon.

Mr. NICHOLS. We will talk about that. Mr. Kasich.

Mr. KASICH. Thank you, Mr. Chairman. Doctor, let me ask you this question. Is it true that in the wartime contingency plans, the Air Force believes that the hospital at Wiesbaden would be destroyed early on in the conflict, and the Army thinks it will not be? We have one service saying, we can count on this hospital, and the other one saying "we cannot."

Dr. MAYER. It was true. It is no longer true, Mr. Kasich. We have switched as people try to imagine what the nature of future war would be, and how things would operate. We have come to the realization that airfields which in past days were relatively immune to significant attack early on, are certainly going to be immediate first-day targets, and may, in fact, generate a great many casualties right on scene.

This is something of a switch from the way things have been in the past. In keeping with that, it was originally thought by some, certainly not by all in the Air Force, that Wiesbaden would probably have to be abandoned. Because there wasn't close joint planning, at the same time the Air Force planners were thinking that

they would probably have to abandon Wiesbaden in the early days of the war, the Army planners in Europe, the few people that there were, had an idea that, regardless of what happened early in the war, they would probably move in, expand Wiesbaden, and utilize this as an Army or a joint activity.

It is now clear and there has been a lot more discussion of this, that the Air Force, to the best of my knowledge, intends fully to maintain Wiesbaden in its present state, to expand it as necessary, if a war broke out, and to continue to utilize it. So that has been taken into account in the joint services' planning.

Mr. KASICH. How about the Air Vac, the Army believing that casualties would go out through England, and the Air Force believing they would be brought home immediately, in a conflict. Is that still the program?

Dr. MAYER. I do not really believe that the Air Force policy position is that all casualties would just be shipped back to the United States.

Mr. KASICH. But it is a difference in opinion as to how they are going to be handled, is that correct?

Dr. MAYER. Right. That is part of the problem.

Mr. KASICH. Some shaking their heads, and some——

Dr. MAYER. It is not really so much a difference of opinion. It is a difference in what our capabilities are that have developed. For example, in England, the Air Force has established many, many beds and a hospital that could be used. I think planning has to be realized, to be a fluid process. Beirut did illustrate the fact that there was a need for us to do more cross-service talking and consulting and planning. And, as we examined the differences, it was clear that there were some disconnects. I think those are being very significantly corrected at this point.

Mr. KASICH. I agree with Mr. McCloskey, Mr. Chairman, that somebody ought to be in charge. I mean, it is an understatement to say that we are concerned when we hear that there is no one who is firmly in charge. I mean, we may have somebody who is not directly responsible for medical care, who may be in charge of everybody over there, but we would like to have somebody in charge of the overall medical operation. It really is also an understatement to say we ought to have more cross-service checking. I mean, when Ralph Regula points out that we have helicopters that cannot land on Navy ships because they do not work together, these are systemic problems that, in my judgment, are very serious. I think the chairman, along with Ike Skelton, took a giant leap forward. And, to speak as a new Member of Congress, it is going to change, because we are tired of this interservice rivalry. It costs a fortune—these memos are disturbing as can be.

I hope that you, Dr. Mayer, are going to work closely, as I am sure you are making a commitment, to try to enact a lot of what Ralph Regula is talking about, and what the chairman is talking about, to eliminate this cross-service problem. It is just silly.

And, I tell you, if the public found out about it, they would be more angry about this, Mr. Chairman, than they are about spare parts.

Dr. MAYER. If I may. I do not think that the question within the medical service is so much one of rivalry or of secretiveness to

themselves. The helicopter landing on the ships in Grenada is a good example. It is a very special additional qualification of the helicopter pilot, which has to be learned, to operate a helicopter and land it on a ship. And there were some unqualified pilots. Rather than risk their lives, the lives of the crew, and the lives of the casualties, they were told they could not.

Now, it is easy to say, that should have been anticipated—and it should have been, that is true. That operation was planned from scratch, in something like 6 days. We had not encountered that particular situation before. It did show up, and that is now cranked into our planning factors. But the minute you put something down here, something else pops up over here.

Mr. KASICH. Mr. Chairman, I would like just 30 additional seconds.

Mr. NICHOLS. How long?

Mr. KASICH. Thirty additional seconds. This is just symptomatic of the problem. I mean, a helicopter being unable to land on the ship is symptomatic. I think if we find more about Grenada, we are going to find more examples of the services being unwilling or unable to get along, and that is why I hope that the chairman's bill is the first step toward resolving these problems overall.

Mr. NICHOLS. Mr. Hopkins.

Mr. HOPKINS. Thank you, Mr. Chairman. Dr. Mayer, how long have you been the Assistant Secretary of Defense for Health Affairs?

Dr. MAYER. Almost exactly 2 years.

Mr. HOPKINS. Almost exactly 2 years ago the barracks was blown up at Beirut.

Dr. MAYER. Yes, sir. It was in October.

Mr. HOPKINS. October 23, as I recall. Most of the Members of this committee were members of that investigation. I might tell you that in my view, it really tore this committee apart. It was not an easy investigation. Most of it was closed; the chairman and the Members did a good job; we did not all agree. Nobody is trying to fix blame here today, I am asking you now as an expert, the most expert person we have before us today: as a physician and as an expert, your opinion on the decision that was made by the General to change the route. It was headed, I believe, for Ramstein, and then went to Frankfurt, and eventually some had to come back to Ramstein. Some died.

Could those lives have been saved if that decision would have been different? In your opinion.

Dr. MAYER. No one died, sir, as a result of that decision. I believe that categorically. I have talked to all the principals involved. Certainly no one was injured medically as a result of the change in destination of that aircraft. The people who did die, one of them aboard an airplane, very shortly after it took off, was——

Mr. HOPKINS. He would have died either way?

Dr. MAYER. He was vastly beyond our capabilities to do anything.

Mr. HOPKINS. Regardless of where the plane went?

Dr. MAYER. Yes, sir.

Mr. HOPKINS. He would have died, anyway. That is what you are saying.

Dr. MAYER. Yes, sir. I do not mean to imply though that it did not increase the risk. It did increase the risk.

Mr. HOPKINS. That is right.

Dr. MAYER. Perhaps for some.

Mr. HOPKINS. Let me ask you this. I am interested in Congressman Regula's statement on page 2. He stated that "In a March 1985 interview the Assistant Secretary of Defense for Health Affairs stated the armed services could care for only 3 of 10 people who might be wounded in battle today." I believe he attributes that to your statement.

Dr. MAYER. Yes, sir.

Mr. HOPKINS. Do you think our priorities are a little fouled up, Doctor?

Dr. MAYER. Indeed, I do, sir. And that is why I welcome this opportunity.

Mr. HOPKINS. Help this committee; help me a little bit. I believe we have about $9.6 billion allocated in the DOD budget.

Dr. MAYER. Yes, sir. Except for the $46 million that they have cut out for the desperately needed military construction overseas for medical readiness.

Mr. HOPKINS. My question to you, Doctor, is this. From a priority standpoint, what higher priority could we have than to get a better ratio than 3 of 10? Do we have too many gynecologists? Do we have too many obstetricians? You are the No. 1 person in this area. What are our priorities? Obviously, this is not one. If you, as our expert, state that we can only take care of 3 of 10, obviously, our priorities are wrong.

MEDICAL PRIORITIES

Dr. MAYER. Yes, sir. May I explain first, please, what is meant in stating we are only medically capable both with materiel and personnel, to deal with approximately 3—it is somewhat more than 3 now, it will be 5 within the next year and a half, because we are making real progress. What is meant is if this country were committed to a general war in Europe, that based on the casualty estimates, the number of people expected to be wounded, the length of time it takes at a table to operate on a patient, the number of tables that you have to have, the number of support people you have to have for each surgeon who is operating, we can mathematically determine a figure such as the 3 to 3.5 out of 10 seriously wounded, who could get the initial surgical intervention that they would need to keep our death rate from wounds down to what we consider to be an acceptable level. That level is down around 2 percent which we achieved in Vietnam and Korea and in World War II.

That is in a general war. Now, you have asked this profound and sweepingly broad question about our priorities which sounds simple at first glance, but it is not. We have an equal mandate in the law to provide total health care to 8 million people over and above those in uniform. That includes all our dependents, all the retirees, all the retirees' dependents and all the survivors of people who have been killed on active duty.

That is an enormous health care burden which, contrary to what many people believe, was not part of the original mission of the military medical service.

Mr. HOPKINS. Let me interrupt you for a minute, Doctor. You used the word, "burden." Is that a burden?

Dr. MAYER. Yes.

Mr. HOPKINS. Is it a burden to the extent that we are only—if we have 10 recruits standing in line out here, to go into the Army——

Dr. MAYER. Yes, sir.

Mr. HOPKINS. Where the recruiting officer says, if we get in an all-out war, seven of you guys are going to be in tough luck. That is certain, according to the expert testimony of Dr. Mayer. And that does not, in my view, demonstrate a priority that we really ought to be placing today. I want to help you. I am not trying to be derogatory in any way. I am not trying to be cute.

Dr. MAYER. No, I understand.

Mr. HOPKINS. I am trying to focus in on our priorities. And I have to say to you that our priorities are wrong. I want you to help me to craft the right priorities for our services today, because I, frankly, could not look at a line of recruits with that in mind.

Dr. MAYER. Well, actually, we could not go to war with that in mind, a general war, and conform with the law. We have to be able to provide health care to the number of people that we take into the service.

Mr. HOPKINS. Well, obviously, Doctor, whomever we may be going to war with in the future, and nobody wants that, of course, but they are not going to say, well, we hope you are prepared, because we are getting ready to have a war.

Dr. MAYER. Right.

Mr. HOPKINS. We have to be ready now. According to your testimony, we are not ready.

Dr. MAYER. So far, sir, that is correct. We are not ready, and it is true that without it being a conscious decision, our priorities in the past, in my judgment—and it is always easy to second-guess your predecessors—but, in my judgment, our priorities have not been correct, that is true. And, without wanting to seem defensive about it on behalf of my medical colleagues, the fact that they were given this enormous medical task of taking care of approximately 10 million people—of whom we admit 1 million to the hospital every year, see 56 million outpatient visits—that task was given to them along with the enactment in law that the military medical department provide that total care. What it could not provide, it was supposed to buy outside on CHAMPUS. That requirement was one for which the military health system was not adequately prepared, and was not originally designed.

So, for the last 10 years, military medicine has been playing catchup. We have brought our hospitals, many of them, not all by any means, but many of them like Walter Reed and Bethesda and Malcolm Grow and Travis or Tripler, or Wilford Hall in San Antonio, we have brought them up to a quality comparable to what is available for the civilian community because our soldiers and sailors and airmen deserve it.

But that has been at enormous cost. We have been playing catchup with technology. We have put in the CAT scans as the other

hospitals have done. We have tried to share. We are getting very, very good at sharing resources with the Veterans' Administration. We have commitments from civilian hospitals and we have many interactive relationships with them, but it has been a massive task placed on the shoulders of the military health care system.

To do this total health care enterprise, we are also maintaining full medical coverage for the 350,000 dependents we have got in Europe besides the 350,000 uniform people. And, because of the need to do that, attention was not adequately given to the fact that we had medical gear stored in Germany that had been stored there for 40 years and never looked at, that we did not have enough beds in Korea, that we do not have aeromedical staging facilities where we need them. And that we do not have the exact mix, by any means, of medical and surgical specialties that we would need in wartime.

We are not at war, and just as in trying to keep geared up for disaster, if you do not have disasters, interest tends to diminish. So, we are—it is true—we are short of surgeons and anesthesiologists and surgical nurses and psychiatrists to go to war. We are handling, with great effort, and some of our places are terribly overworked, we are handling with great effort this peacetime health care system.

We are trying to bring in a lot of the CHAMPUS work that we pay for out in the community in a system that, nearly alone in the United States, pays anything that the doctor bills. We have no controls over CHAMPUS. The patient is essentially an independent contractor with the power of the U.S. Government behind him to go out, go to a doctor and say, I want this and if the doctor agrees, he gets it, and we pay for it. And we are trying to recapture a lot of that back into the military facilities, but there is a limit as to how much of that business we can pull back in without driving our doctors and nurses out.

Mr. CARNEY. Will the gentleman from Kentucky yield for a moment?

Dr. MAYER. I am sorry.

Mr. HOPKINS. I would be glad to yield.

Mr. CARNEY. There is a conflict that we should all recognize as we approach this problem. No. 1, you say that we can only take care of three, and maybe we move to five. I would suggest that never, in the course of history, has any nation been able to maintain five. If we get there, we should tip our hats.

No. 2, one thing you have to recognize with providing medical care is the skills of the professionals. They are only good if they are doing their work. You cannot have professionals in the military sitting around so you can fill out a form and say, well we can meet 100 percent of an all-out war requirement. Those people, if they are going to be good, they are going to have to be in trauma centers in civilian life around this country, practicing their profession. If they are not practicing, and they are in the military, when the time comes to utilize them, they are going to be useless. They are not going to know the techniques of modern medicine. So we have to recognize one thing. We cannot have our cake and eat it in this situation.

We cannot have a capability of meeting an all-out European war, the medical requirements, and expect to have good people there. It is impossible. They have no place to practice. We cannot have the type of table of organization we would like when this Congress, in 1973, gave up the draft. Why would a doctor want to come into the military if he cannot practice, if he had to fill a slot and sit there and twiddle his fingers while his colleagues were in civilian practices, learning their trade, practicing their trade, when this fellow might see one person on sick call every day.

We just cannot have it. Now, we have to recognize that, and the public has to recognize that. So, I would be a little bit cautious about saying what is appalling and what is not, and what the public would think. This is not a situation—we are talking about an all-out tragedy, when the doctor said we can only meet 3 of 10 casualty requirements. I am not shocked at all by that.

And I would say again, if we get to five, as the Doctor suggests we would, that would be the best that has ever been accomplished in any modern military organization, be it the Soviet Union, the United States, or Britain, or anyone you can imagine. That is just the nature of what we are talking about; so I hope we keep that in our minds when we consider the problem.

Dr. MAYER. That is why I tried to point out at the beginning that those figures reflect what would happen in a general war, and certainly we do not expect to be fully equipped with all kinds of trauma surgeons sitting around doing nothing, waiting for a war to happen. And that is one of the reasons it is so important that we do have some responsibility for giving health care to our dependents and retirees, because it does keep our surgeons and orthopedists occupied.

But, we are not anywhere near in danger of having a doctor sitting around twiddling his thumbs at this point, and for the foreseeable future.

Mr. CARNEY. But you would be if you could answer the question to this committee, yes, we can meet 100 percent requirement for medical personnel in an all-out war. You would have doctors sitting around, waiting for that war, twiddling their fingers, and losing their proficiency.

Dr. MAYER. We do not think that that is quite true. We could greatly increase and change the mix of the kinds of positions that we have, increasing the surgical specialties. We have approximately 100 percent of our expected requirement for people in internal and general medicine. And, it should be remembered that in war, fully half of the people in the medical system are there due to injuries and illness, not due to being wounded.

As I said, there is an obvious need for us to maintain a viable patient population to keep sufficient numbers of the right kinds of physicians available in the event of war. And we can get much closer to 10 out of 10.

Mr. CARNEY. Can you do it in the area of trauma surgery?

Dr. MAYER. Probably not entirely. Partly because trauma surgery and emergency medicine today, which are relatively new specialties in medicine, are not over-populated specialties to begin with.

Mr. CARNEY. But, Doctor, you could not maintain the levels needed for an all-out war in a peacetime military—it is impossi-

ble—and expect those doctors to be proficient. It is absolutely impossible. You would have a problem of boredom within the professional field.

Dr. MAYER. Well, as I say, we are nowhere near approaching a situation——

Mr. CARNEY. Well, I understand that. But I am just saying that we have to recognize that you can never answer that question during peacetime, saying that we have the ability to take care of 100 percent of the wounded in an all-out aggressive activity in Europe.

Dr. MAYER. I should also add the caveat that what we are talking about is not the long-term conduct of an overall war in Europe. I am talking about the first 30 days of a major confrontation.

Mr. NICHOLS. Gentlemen, time.

Doctor, let me switch to a different aspect of your testimony. Mr. Regula, I believe, made a statement that 20 percent, roughly a fifth, of our doctors are unlicensed. I think sometimes the quality of military medicine has not been given its full due. I had occasion during the August recess to utilize the services of Bassett Army Hospital in Fairbanks, AK, and that is about as far as you can get from civilization. The doctors and the nurses—you know, it is a page right out of M*A*S*H; they operate in combat boots and OD's. Well, my wife developed a kidney infection. I am retired military; she is a dependent and is entitled to military care. And I cannot say too much for the quality of military medicine that those doctors and those nurses provided.

I am, however, concerned about the fact that perhaps 20 percent of our people are unlicensed. Would you break that down in terms of doctors, dentists, and nurses? Why is that so, and what are we doing about it?

UNLICENSED DOCTORS

Dr. MAYER. First, I have to tell you, sir, that at Bassett when you were there, fully 20 percent were unlicensed, maybe 50 percent. And the confusion arises from a failure to understand the exact meaning of licensing in medicine in this country at this time.

The average civilian physician goes through medical school, and through his first post-graduate year of medical training, which in the medical school I went to, was required before they would even give you your final diploma, and at that point, when everything is fresh in your mind, you take a state licensing examination. This is the way it has been for many years.

In recent years, there has been the development of the National Board of Medical Examiners. And they produce examinations which are disseminated throughout all the medical schools. All States, except two, use those National Board examinations, part of which are given at the end of your second year in medical school, and part at the end of your final year. They use those as the requirements for licensing. So, many of our physicians, the ones who do not have the license, have successfully completed, essentially, the requirements for licensing, but have gotten their graduate medical education in the Armed Forces, have moved directly from school into active duty, and are likely to be uncertain as to where

they are ultimately going to settle down—particularly, if they are contemplating the possibility of an entire career in military medicine as a great many people are.

There is no need for them to take an individual State license. It used to be a great can of worms because the license in South Carolina provided different requirements from that in California, from those in Florida. Some of the States have used licensing exams to make sure that outsiders did not come to practice in their State, because the exams are so tough you could not possibly pass them, unless they said so.

So, now there is a general leveling, there is no national license, but there is this voluntary body that most States use for National Board exams.

Mr. NICHOLS. Well, the figure of 20 percent does not give you any heartburn?

Dr. MAYER. Absolutely not. None of those people that we are talking about in that 20 percent are incapable of getting licensed, and that should not be inferred from the statement that they are not licensed. They have not taken a licensing exam or a separate one in a given State, because they have not chosen to settle any place, but they are fully qualified physicians. It is very difficult to explain that simply to the satisfaction of most people, because they have a kind of a comfortable feeling I think, that by God, if you have got a license, you must be qualified. Even that is not necessarily true in the profession of medicine as in any other profession.

So, nonetheless, because of the fact that we are serving the American people, and the parents of the kids who come in and the kids themselves, and because the average person like you is shocked, to think, my goodness, is the service using unqualified doctors? That is not true. We are not using unqualified doctors at all.

Mr. NICHOLS. Would you say that 20 percent would be about the norm in civilian life?

Dr. MAYER. Well, no. In civilian practice, if you are going to do work at all, you have got to get the license, just like if you are going to do—well, all right.

Mr. NICHOLS. Why should we not have that?

Dr. MAYER. There are some who practice without licenses. But there would be a very small number of people, I believe. I am not expert on what the statistics are in the civilian community, but when I was myself a Commissioner in California, the number of people who showed up actually practicing medicine without a license, which were of concern to me, was very, very small. They are normally uncovered very quickly. I am not talking about those kinds of people. I am talking about fully qualified physicians and dentists who have taken the same exams, have completed the same medical schools, who have gotten their graduate training in our hands, so we know exactly how qualified they are, who simply do not have the technicality of an individual state license. We are going to correct——

Mr. NICHOLS. But if the civilian sector requires it, it seems a little strange that we, in the military, would not have the same set of standards. I am asking as a layman.

Dr. MAYER. A license to practice, in the past, and I am not uttering an overall condemnation of licensing practices in the various states, but in many States a license to practice medicine has been of the same quality as the license to peddle pots and pans. It is a business license. It is some assurance to the State that you did go to medical school, and that you can answer a reasonable number of questions about what you do. But it is basically permission to conduct a business in that state. We do not require that in the Armed Forces, and we are going to.

We are going to mainly, however, not because we are fearful that we will find anybody who cannot pass a licensing exam, because we will not take them, but because the perception that we have unlicensed, and therefore, unqualified doctors, which is a totally erroneous association, has got to be put to rest.

Mr. CARNEY. Mr. Chairman? Mr. Chairman?

Mr. NICHOLS. The staff has brought to my attention that there is a new DOD directive signed just this summer——

Dr. MAYER. Yes, sir.

Mr. NICHOLS. Which would require——

Dr. MAYER. Yes, sir.

Mr. NICHOLS. Licenses for all doctors, dentists, nurses, and psychologists in military hospitals.

Dr. MAYER. Yes, sir; we agree that it needs to be done, but I want to make very clear that we are doing it because we have a problem that identifies unlicensed with unqualified. That is not true.

Mr. NICHOLS. I think that would be in the minds of an average layman.

Dr. MAYER. I do, too, and that is why we took that step.

Mr. NICHOLS. If you are going to be operated on in the morning, and somebody says, you know that guy does not even have a license, well, I would be looking for another doctor. Mr. Carney.

Mr. CARNEY. Mr. Chairman, I think I understand your explanation about a young physician who comes out of school and determines that he would like, or she would like, to make a career in the military; or a young physician who goes into the military, perhaps on a contract for receiving a medical education.

Dr. MAYER. Yes.

Mr. CARNEY. But, particularly in the United States, we have a corps of civilian physicians filling billets, and we have run into a problem there where they have not been licensed. For example, that anesthesiologist or anesthetist—whichever he might have—he was nothing, he was not licensed, he was a fraud, he is in jail. Now, that fellow got into the service, not as someone coming out of medical school, but someone who fraudulently practiced medicine for 20 years and then found himself a job. Now, that is the type of thing that is of great concern, I am sure, to everyone. What are we doing to prevent that from happening again?

Dr. MAYER. We have long since taken very significant steps in every branch of the service to make sure that that cannot happen. We have to see the documents.

Mr. CARNEY. He was not in the service, if I——

Dr. MAYER. No, I understand.

Mr. CARNEY. He was a civilian.

Dr. MAYER. He was a civilian employee. When an individual physician comes into the service now, the chances are very great that he is one of our products, that is, over 70 percent of all new ascensions in the medical corps, are people who have either come through our scholarship program so we know them intimately and know the level of their performance, or they have graduated from the Uniformed Services University of Health Sciences, or they have done one or the other and are entering after a delay permitting them to get graduate education on the outside.

So, less than 15 percent of new people coming into the medical departments of the Armed Forces are coming so-called off-the-street. Now, those physicians are the ones who, thanks partly to that quasi-anesthesiologist, and partly to an increased awareness of the fact that there are frauds out there who try to take advantage of it, and partly because of a very heightened interest in the services on quality assurance, which has to begin with credentialling after all, any person coming into the service today, has to present us with original copies—and even those could be fraudulent—if we have any doubt at all, we will send the diploma back to the medical school with a picture of the applicant, and say, is this the guy you gave this to?

We will not let anyone sneak into the service with false credentials, credentials from nonapproved medical schools, excuses that they took their training in Bulgaria or someplace, and they cannot get a copy of the diploma. None of that will sell anymore. I can assure you that the chances of that happening are just literally beyond any possibility.

Mr. CARNEY. Thank you.

Mr. NICHOLS. The Chair is going to recognize Mr. Regula.

Mr. REGULA. Thank you, Mr. Chairman. I was curious. You mentioned about your trying to pull the CHAMPUS program back into the military environment because the cost is beyond your authority to control. I am concerned about that because the health care delivery system in toto, military, civilian and so on, is a cost to society. And we are confronted with the fact that it has escalated rapidly; therefore, we are seeking ways to get cost efficiency, as a result of DRG's in particular——

Dr. MAYER. Yes.

Mr. REGULA. Many of our civilian medical facilities are probably underutilized at present and, therefore, in terms of a total delivery system, it would seem appropriate to use those facilities through CHAMPUS as a means of supplementing the military system and, thereby, reducing the total cost to society.

I guess I am concerned that you say you have no control over costs. In Medicare we have tried to establish some controls through DRG's and position freezes and you are saying that where you are required to reimburse under CHAMPUS, that you cannot control what is charged. I would be curious as to whether there should be some policy decision to put in the form of legislation that gives you control in CHAMPUS comparable to what we have in Medicare so that we could use those underutilized facilities to meet the requirements of the law for dependents. It would be better for them. It would be better for the total cost of medical care to society, to the elective society of the United States. So I would like to have you, at

least, respond as to whether you think the Congress should address that cost factor in CHAMPUS in an effort to utilize our military facilities more effectively.

CHAMPUS

Dr. MAYER. There is a place for you in Health Affairs anytime. We, indeed, did submit a legislative proposal this last year to require that any hospital that accepted Medicare patients which are also paid for by taxpayers in a Federal program, and reimbursed on the basis of DRG's, be required to accept our CHAMPUS patients on exactly the same basis. This requires a legislative enactment, and we got nowhere with it. Medicare presently produces 40 percent of all the patients in U.S. hospitals. CHAMPUS produces less than 1 percent. We are faced with a situation, without legislative mandate to the hospitals that if you are going to take one, you are going to take them both on the same terms. Without that, the hospital is free to say, you cannot control what we charge you or we just will not take your patient. Or we will charge the patient all the rest.

So, yes, we need legislation to tie the reimbursement system under CHAMPUS for hospitalization to the reimbursement system for the other Federal programs, particularly, Medicare.

It is true that CHAMPUS or some civilian health care is a very important part of our system, but it is equally true and of great concern to me that we control, not only the cost, but the quality, the utilization, the selection, the appropriateness of care. We do not have really anything to say about it, if the patient goes out for any outpatient procedure they want, including outpatient surgery which is becoming more common and more expensive. We do control, to a certain extent, their admission to a civilian hospital because they are required, if they live within 40 miles of one of ours, to get a certificate from us attesting that we cannot do it for some reason. That is the degree of control.

But the health care market today, throughout the country, is a buyer's market. It is one in which there are too many empty beds. We have overbuilt in this country. The costs are escalating. A lot of the businesses are no longer content to just buy medical services for their employees, they are setting up their own health care payment system. And I would like to see CHAMPUS move in the direction of giving more responsibility to the military health care commander in an area, not just to ship his patients out as independent contractors with the Government's Treasury behind them but on the basis——

Mr. NICHOLS. Will the gentleman yield?

Dr. MAYER. I am sorry.

Mr. NICHOLS. Will the gentleman yield to honor my question now? I am very interested in this particular aspect of discussion here today. Military people take great pride and every recruiter in this country signs people up by telling them, keep your nose clean, dance with the colonel's wife, and don't get in any trouble, and 20 years, you know, you're going to use the PX, going to use the commissary, and you'll have medical care. You're on the retired list.

Dr. MAYER. Right.

Mr. NICHOLS. Go to any military hospital in the country to get treatment, right. Are you suggesting by chance that that feature might be dropped and you can scuttle these retired people?

Dr. MAYER. Absolutely not.

Mr. NICHOLS. And their dependents who have——

Dr. MAYER. No, sir.

Mr. NICHOLS. Taking all of them on down into CHAMPUS or into Medicare.

Dr. MAYER. I am glad you asked that. Because, it gives me the opportunity to assert very firmly, contrary to at least one erroneous press report yesterday——

Mr. NICHOLS. I have a parochial interest in asking.

Dr. MAYER. Well, I am a retiree, too. I want it. [Laughter.]

No, sir. We are not planning any such thing. It is necessary, as Mr. Carney pointed out, to have a certain medical caseload to keep a qualified group of physicians occupied, their skills honed, and so on. It is equally important to the welfare, morale and the essential contract that has been entered into between the Government and the person who signs up for military duty, it is essential that we not erode the medical benefit that is available under the present scheme.

But, make no mistake, that benefit has limits. It is not always available, it is not possible for us to give that whole benefit in every instance in every location. That is why we have CHAMPUS. What I would like to see is CHAMPUS modified, and we are working on proposals and schemes to do this, to see some modification of the way we utilize our civilian colleagues in medicine, to give that part of the care which we cannot give, and which we will guarantee to our people, to give it on the basis of contractual relationships with our medical installation commanders, with the Department of Defense, or the services' departments, so that we can take the fullest advantage of our tremendous buying power as a huge organization and the competition that exists out there today, and so that we can write into the relationship the quality controls that have to be there.

Mr. NICHOLS. Thank you. Mr. Hopkins.

Mr. HOPKINS. Doctor, I want to ask you about the peer review organizations or PRO's, and——

Dr. MAYER. Yes, sir.

Mr. HOPKINS. I have some problems with acronyms on this committee.

Dr. MAYER. So do I.

Mr. HOPKINS. They keep coming up, and I do not know what they are, and I do not think you can stay around here enough semesters to learn them all. I have the same problem even in your field, as an example. In the vernacular of doctor, he is practicing medicine. Well, when I go see a doctor, I do not want to go see one that is practicing—I want the practice time to be over when he sees me—this is the real thing when I am there—in my mind.

And I relate that, I guess, somewhat to the chairman's question about licensing. Are you telling me that a doctor, Army, the Navy, whatever it might be, who is shipped to Alabama and does not have an Alabama State medical license is technically not qualified--not qualified may not be the right word, I suppose?

Dr. MAYER. He is not authorized to exercise his skill outside the confines of the Federal Establishment. He could not go downtown in Anniston or Dotham and practice medicine.

Mr. HOPKINS. Do you see that as a major problem?

Dr. MAYER. Not at all.

Mr. HOPKINS. Not at all.

Dr. MAYER. No, sir.

Mr. HOPKINS. It is, I think, in the minds of people, like the chairman brought out.

Dr. MAYER. Correct.

Mr. HOPKINS. He does not; as I do not want someone practicing on me. I do not like to think somebody who is not even licensed is going to be working on me. And that is a problem. Is there anything we can do about that?

Dr. MAYER. Yes, for one thing, I have issued a directive that all physicians who do, who independently lay hands on patients and are responsible for patient care, must have a license to practice in some State in the United States, in full knowledge of the fact that that is not good enough for us, that that is a most minimal requirement.

Mr. HOPKINS. Yes, sir.

Dr. MAYER. There are requirements for what doctors can do that far exceed any licensing requirement.

Mr. HOPKINS. Now, let me ask you this question, Doctor. This summer you announced that the Department of Defense plans to contract with civilian peer review organizations to monitor quality of care in military hospitals. I would like for you to expand on how you perceive this being implemented.

PEER REVIEW ORGANIZATIONS

Dr. MAYER. Yes, sir. I would be very happy to. We have a request for proposal out which is of great interest to the Association of Peer Review Organizations which have achieved a degree of acceptability and, in fact, endorsement from Medicare, from the Department of Health and Human Services, and have banded together in their own professional organization. We have an expression of interest from the American Medical Association and others to respond to this request for proposal for a civilian organization which must be operated by physicians to arrange for established peer review organizations which meet the specified requirements. They must be physicians, they must be board certified—there is some argument over whether just Board eligibility——

Mr. HOPKINS. Well, will they be monitoring the quality of care?

Dr. MAYER. Oh, yes. That is what we are most interested in having them do, is to monitor as an augmentation to our own, very extensive quality of care system, but bringing a fresh look from the people who are in practice in the community, who know what the standards of care are in their own communities. You know that every hospital that accepts Medicare reimbursement has to be reviewed by these PRO's. So, we are saying, come in and look at the following things. We will tell them the kinds of things that we have established and the national accreditation bodies have estab-

lished as the incidents or the types of diagnoses that bear looking at, at least on a sampling basis.

Mr. HOPKINS. Are you getting any resistance from any of the services on this?

Dr. MAYER. No. We are not getting resistance. We are getting a certain amount of uneasiness and fearfulness that maybe the civilian doctors who come in will not really understand the special conditions under which we deliver health care, they might make judgments that are unfair, there is uneasiness that since there is no absolute standard of practice that obtains throughout the country—we cannot say that out of every 100 appendectomies, 20 are going to be infected or less. There is some fear among the services that the result of the PRO's looking at our quality, if they come to public attention, may be used by those whose object it is for a variety of purposes to put down military medicine, to criticize us.

Mr. NICHOLS. Excuse me, a moment, Doctor, I am sorry. This is on passage of Senate Joint Resolution 388, Continued Appropriations, fiscal year 1986. The subcommittee will stand adjourned for about 10 minutes.

Dr. MAYER. Thank you, sir.

[Whereupon, a brief recess was taken.]

Mr. NICHOLS. The subcommittee will come to order. Dr. Mayer, you mentioned that it is your understanding that the Appropriations Committee had deleted all of your overseas military hospital construction projects.

Dr. MAYER. The readiness ones, sir, yes.

Mr. NICHOLS. Yes. Could you just ballpark identify those projects for us? Is it hospital construction; is it additional beds; is it equipment?

Dr. MAYER. Yes, sir. The list includes the fleet hospital facilities necessary to pre-position fleet hospitals for the Navy in both England and Guam; Air Force pre-positioning sites for field medical gear at Torajon in Spain, Kimhae in Korea, Ankara in Turkey. Those are all our readiness——

Mr. NICHOLS. That is three Air Force hospitals.

Dr. MAYER. Yes, sir. Torajon, Kimhae, and Ankara. Three Air Force hospitals, two Navy fleet hospital facilities.

Mr. NICHOLS. What is the aggregate number of beds we are talking about?

Dr. MAYER. Pardon me, sir.

Mr. NICHOLS. How many beds?

Dr. MAYER. I can get that.

Mr. NICHOLS. Would you provide it for the record?

Dr. MAYER. I certainly will, yes, sir.

[The following information was received for the record:]

NUMBER OF BEDS ASSOCIATED WITH HOUSE APPROPRIATIONS COMMITTEE (HAC) MILCON CUTS

By deleting three Air Force hospitals and two Navy fleet hospitals from our FY 1986 budget request, the HAC on Military Construction has reduced our planned contingency hospital capacity by approximately 2,200 beds.

Mr. NICHOLS. I have another question I want you to respond to. You remember that Congressman Regula was responsible for the

provision in this year's defense authorization bill that requires you to prepare a report on revising the organizational structure of the military health delivery system. We want to be sure that that report will be a serious effort to assess problems and recommend realistic corrective action. Would you tell the committee how you plan to conduct the study leading to that report?

Dr. MAYER. Yes, sir. I would be happy to. As was mentioned by one of the members, there have been not less than 21 such studies since the 1940's of military health care. Many of them have recommended various schemes for restructuring or reordering military health systems. Our efforts to conduct that study will, first of all, necessarily have to review those, as we already have done in connection with the study of 2 or 3 years ago at the behest of the Senate Armed Services Committee, on the feasibility of establishing a defense health agency. We will have to review the principal findings and recommendations of all the studies that have gone before.

Then, each of the services in that same bill, as I understand it, is required to conduct its own study and to report that to the Congress through the Secretary of Defense, and we will engage with the people in the three services who are doing such study, not in any attempt to make sure that everybody is saying exactly the same thing at all, but to take into account the kinds of concerns and ideas that each service has. A number of the things that are stated as the objectives of such a reordering or restructuring are things which are exact duplicates of recommendations that emerged from the Blue Ribbon Panel on Sizing of Military Medical Facilities, and we are already engaged in pursuing those recommendations very directly. So, in coming up with a study, it is necessary, obviously, for us to look at the mix of patients that we have today, the command structure as it exists in all three services, the relationship between the services and the Department of Defense and the Office of Health Affairs. We will attempt to explicate each of those aspects of what you have asked for, which is really a major look at the whole way we do business. If I am mistaken in that, that it is not a major look, that it is the end of it in some way, I would very much appreciate your counsel and advice.

Mr. NICHOLS. Have you started that study?

Dr. MAYER. Yes, sir, we have partly because we were required immediately to begin to implement the recommendations of the Blue Ribbon Panel because the Secretary adopted them.

Mr. NICHOLS. Remind me. Was there a timeframe on it?

Dr. MAYER. Yes, sir, 6 months from the date of enactment.

Mr. NICHOLS. Six months. All right. One final question, here. You said, I believe, that you recommended to Secretary Weinberger that the Command Surgeon in Europe be a full-time flag officer, with clear authority to review and oversee joint medical planning for all three services. Has the Secretary acted on that recommendation?

Dr. MAYER. Well, he accepted that recommendation, and——

Mr. NICHOLS. He accepted it. And will you tell me that he intends to do that?

Dr. MAYER. I believe that the——

Mr. NICHOLS. I am not asking you to speak for the Secretary.

Dr. MAYER. Yes, sir.

Mr. NICHOLS. I am just asking you to share what knowledge you have as to how that recommendation was accepted. Did he indicate his support of it?

Dr. MAYER. Yes. He did indicate his complete support for that idea, and he passed it to the Joint Chiefs of Staff for implementation. Our communication with the Joint Chiefs revealed in the more than a year since that recommendation was made and accepted, that they are working on it, and that they agree in principle, but that there are problems within the services in identifying a general officer, or flag officer for that purpose.

Mr. NICHOLS. Well, that is frequently the case with the Joint Chiefs of Staff and it should be. People ought to speak their mind, and ought to be heard; but inasmuch as a year has passed since that recommendation was placed in their hands, I am just curious as to what stage it is in.

Dr. MAYER. We share that curiosity, Mr. Chairman.

Mr. NICHOLS. Mr. Carney.

STATEMENT OF HON. WILLIAM CARNEY, A REPRESENTATIVE FROM NEW YORK

Mr. CARNEY. Thank you, Mr. Chairman. I do not have any other questions, but if I may, I would just like to say a few words for the record.

I think we have to be very, very careful as we approach this problem. The delivery of health services to the military is unique in many, many ways. You deliver health care to a community and you have one or two missions. One, the everyday health care; and two, you have to be prepared for tragedy, earthquake, that type of thing, but nothing on the level of the types of changes the military has to be prepared for.

And we have to recognize that when we try to compare health care services in the military. We have to recognize that the missions in peacetime are completely different from those of wartime. When planners in the Pentagon plan for different types of aggressive activities, there are many scenarios—limited war, all-out conventional war, nuclear war. You have to have preparations in place for handling all those types of things.

It is not an easy task. So, it seems to be easy for us to criticize, and I think we should just be somewhat careful. We have to recognize the limitations that you have. I think one of the profound effects of eliminating the draft can be seen today in medicine in the military. You have to compete for professionals and it is very, very difficult. Given the cost of an education today for a doctor or a nurse or anyone in the medical profession, it is almost a requirement that they get out and actively produce an income, pay back their loans, that type of thing, and it is difficult for you to compete under the circumstances.

You have to deliver health care, as the chairman pointed out, to some of the most rural places in the world, even within the continental United States, in Alaska, but we have to do it in many other countries. So when you look at raw statistics such as bed census, they can be very, very misleading.

You, obviously, have to stay abreast of the most current techniques in delivering that health care, and that requires that those in the professions are practicing continually, so their proficiency levels are such that they can give the best type of health care; and that is what has to be expected when a young man or a young woman in service is preparing himself or herself for an operation, be it a simple operation or a difficult neurosurgical technique; he wants to have the confidence, or she wants to have the confidence, that that surgeon is a qualified surgeon. And the only way surgeons can be qualified is if they have a proficiency and that requires doing certain procedures continually, not too many, not too few.

There is an accepted mark when you are doing open heart surgery. If you do 200 procedures per year, you are probably very proficient; if you are doing 400, you are maybe doing too many; but if you are doing 13, that patient is in a lot of trouble, I would suggest.

So, you have to be careful in dealing with that, but yet you have to maintain that expansion capability. You are unique inasmuch as you have to have bricks and mortar or portable types of facilities to provide emergency-type health care.

We are woefully inadequate in that area. Before this hearing, I recognized that, and I think the chairman has and members of this committee have. And you pointed that out very succinctly when you gave us the statistics of the availability of expansion in Korea, where that is a hotspot of the world, where conflict could break out at any time. We are not ready for it over there in my estimation, and I am depressed to see that Congress did what it did on the appropriations aspect of pre-positioning equipment there.

And I would just hope that this is not the last hearing we have, Mr. Chairman; that we have an opportunity to go through the process as you present to the Congress the report that we directed you to do; that we work with you as you progress through that report; and that we have a better understanding of the problems that you are faced with.

And I think that ofttimes what happens in circumstances like this is that people go off and get emotionally involved, and we really miss the substance because we are dealing with the perception. We can ill afford to allow that to happen in this area. We cannot deal with perceptions here. We must deal with reality. That is our responsibility as a Congress, to try to explain to the public precisely what the mission is. It is your responsibility to explain to the Congress and the public.

And we cannot afford at all to allow an erosion of confidence in the medical area in the military to happen, because it would affect, as the chairman said, the recruiter. If a recruiter cannot provide the type of health care that someone believes he or she is entitled to—we are not going to get people in the military—so I would hope this is not the last hearing, and I commend the chairman. This was really a very informative hearing. And it is a very, very important topic and I am glad that you called it.

Mr. NICHOLS. Thank you. Mr. Kasich.

Mr. KASICH. Mr. Chairman, I agree with Mr. Carney when he talks about perception, reality, and not being emotional. And I heard Dr. Mayer talk about, in answer to your question, somebody

working on it, and the Secretary has accepted it. We are asking what those mean, those code words—that to me means helicopters that cannot land on Navy ships, and contingency plans that are not put together appropriately.

I have just really two questions No. 1, how did this go on for 25 years? How was it that nobody was working together and we have the Army, the Navy, the Air Force, and the Marines all planning their own way? How is it that these things happen? No. 1, I wish you would answer that. Why has it taken you to go in there to start saying we are going to pull together?

Why did this happen?

Dr. MAYER. I cannot answer it to anyone's complete satisfaction, but I can make a try.

Mr. KASICH. You will make people mad if you answer it right.

Dr. MAYER. It really is not a simple answer that is possible for that. One thing that has to be remembered and gets lost in all our deliberations and some of the emotions that are connected with these very serious issues, is the fact that the services have consistently conducted a very high quality of medical care since I have been associated with them, which is in the 1940's.

And, it is a medical system that within each service, the members could justifiably be proud of the care they delivered. They turned to, like the Navy did at Beirut, like everyone did at Beirut, and they took care of people. They have enjoyed the great confidence of the line. Generally, military medicine has had great support from the Congress. And a large part of the problem is that in being given this enormous additional mission, which is terribly important and which we must do for our beneficiaries and for our retirees, but in being given such a massive additional mission for which the system was not designed at all, and that is a mission that goes on every day, day or night, regardless of whether there is a war or not—we have got those 10 million people out there who look to us for our care. That has produced an enormous stress on the system. Many of our facilities were built during or even before World War II. Just to put some of them back in shape, to repair hospitals that have cracks in the walls, has required a large portion of our budget. Since we are just a limited part of defense, we can plead a special case up to a certain point, but there is just so much money, and in trying to make the best use of what we had and having a 24-hour-a-day demand for high-quality health care, attention simply was allowed to slip.

And, I cannot blame anybody. I do not know exactly why the individual decisions were taken as they went.

Mr. KASICH. Is that also because it impinges on present service-unique prerogatives to decide wartime concepts and how funds should be spent for medical supplies and facilities, because it impinges on present service-unique prerogatives?

Dr. MAYER. The case could be made that that is part of it, but I think in justice it has to be said, that it is not just prerogative. The services, after all, are really quite different from one another, particularly in combat. Two of the services have existed for 200 years, and have over those 200 years developed procurement systems, logistical supply systems, independently of each other. Now some-

body comes along like me, and says, we have got to put all of that logistical system into one place.

Well, it is done by a different agency in the Army than it is in the Navy; it is not an exact counterpart. The Air Force came along in 1949, 2 years after the Air Force was founded, before they even had a medical service, they used a systems approach to developing a medical care system which has fit very nicely. I think it is a superb system for supporting the various highly specialized commands within the Air Force.

Now, trying to put them together because of the obvious disconnect that takes place, particularly now that every military operation is a joint operation, is hard. It is also very hard to conceive of an operation that does not involve all of the services. Trying to marry these up and put them together is difficult, and I would just plead that we do not plunge too quickly into the idea that we could just put them all into one organization, put somebody in charge of it all and it would be fine. I am not a purple suiter.

There clearly are ways that we can work better together. We are doing it.

Mr. KASICH. It is interesting, though, that it is a civilian who is trying to get the military to work together, rather than a purple suiter who is working to try within the military to get everybody to work together.

Dr. MAYER. Most of my adult professional life was spent in the Armed Forces of the United States before I retired, so I can hardly be said to be—you never get over that. [Laughter.]

Mr. KASICH. Thank you, Mr. Chairman.

Mr. CARNEY. Did you dance with the colonel's wife?

Dr. MAYER. Pardon me?

Mr. CARNEY. Did you dance with the colonel's wife?

Dr. MAYER. Not until I got to be a colonel.

Oh, may I, Mr. Chairman, just say one thing, because I have left out an enormous part of our whole medical readiness posture, and it was in failing to respond adequately to one of your questions, that I failed to do this, and that has to do with our reserve.

Our reserve medical forces constitute at least half of our capability for conducting medical activities during war, and in the reserve, too, we have the problem of mix. Now, the reservists are not instantly available. I am first of all concerned with what happens the minute a war breaks out. I do not know that we are going to have time to mobilize, I only know that the only people that can get sent overseas that day are the ones now in uniform.

So, we have to concern ourselves with that first 30 days, we can mobilize the reserves fairly quickly, we can backfill behind the people we have to take out of Bethesda and Walter Reed and Malcolm Grow and send overseas at the drop of a hat, but there is some lag time in that. Some of those reserve units will be directly sent overseas. Some of them are in a very high state of readiness. For example, in medical evacuation, 95 percent of all the personnel engaged today, in medevac, are reservists on temporary active duty. And, in fact, ultimately it may be as much as 99 percent of our medevac capability will be handled by reservists.

So, we are able to see a time when, between our active forces and our reserve forces, we expect by 1990 or 1991, to have in place suffi-

cient materiel, sufficient people signed up, sufficient distribution of the kinds of specialties, whether trauma surgeons or gynecologists, too. You know, we have a lot of women in the service today, and gynecologists often can do the kind of general surgery that we need. We are going to have to look into more cross-training both among our reservists and our active forces, but we actually can see the time when we can give the level of care that the people are entitled to.

And one last thing, when I say that we can only take care of 3 or 3½ out of every 10 wounded, in the event of a general war, massive instant general war, I think it has to be understood that the other 6½ or 7 are not going to die. We may never be able to get to the whole 100 percent, as you suggest, so that everybody can have the finest level of instant trauma surgery as soon as he is wounded but the others will not necessarily die. We know that the time people die in war from wounding is the first 8 or 10 hours, they die of shock and hemorrhage and beginning massive infection.

We can achieve a level of medical readiness. And I must say that the services are tremendously supportive and very much involved in our thinking and our planning and our attempts to devise solutions to our specific shortfall. We can see the day when we will be, within the next 5 or 6 years, at a point where that will no longer be our principal problem, but not if they keep cutting out mil-con overseas.

Mr. NICHOLS. Thank you, Doctor. As we conclude this hearing this morning, I do not want to sugarcoat the situation we have in military medical medicine. We do have some problems, we have some things that have been terribly embarrassing to you, to all branches of the services, to members of the Armed Services Committee, things we are not proud of.

I had a situation in my own hospital, Fort McClelland Mobile Army Hospital a few years ago. A terrible thing. But, I would like the record to show that these things happen in civilian medicine as well. If you do not believe that, if anybody doubts that, they only have to look no further than the liability insurance charges being made to civilian doctors in today's world. So, we appreciate the time you have given us this morning.

I would just like to conclude with one final question. And it relates to an article that appeared in Navy Times, September 16, which stated that Vice Admiral Seaton, the Navy Surgeon General, stated right after Beirut, there were scare stories about medical care, but after reviews were in, it turned out that all of those stories were baloney, and I would challenge anybody to go back to see the people who were wounded, and what kind of care they got.

Would you comment on that assessment?

Dr. MAYER. Yes, sir; the scare stories that the Surgeon General perhaps was referring to, had to do with damage to individual Marines as a result of the process that took place.

Mr. NICHOLS. All right.

Dr. MAYER. I have not talked to Admiral Seaton about exactly what he meant. If he meant scare stories about the illustration that we were incapable of responding to a much larger stress—had the ratio of killed to wounded been reversed, for example—if that is what he meant by scare stories being baloney, then I have to say

to you, in my best professional judgment, he is absolutely wrong, that those scare stories were absolutely correct. Now, nobody from my office produced scare stories and this committee, in its investigation, did not produce scare stories. So I am not exactly sure what that refers to.

But, it did reveal serious deficiencies in our planning. It revealed deficiencies in our ability to communicate. It revealed that we still have marvelous, splendid, young men and women in the Armed Forces who can turn to medically and do what is needed. But it revealed that in a different threat, not very much bigger than that one, we would have been in very serious trouble, and in my considered judgment, it would have been not just an embarrassment, but a scandal, to us in the Department of Defense, to the members of the Armed Forces, to the people on this committee, and to the President of the United States, had that been a much larger group of casualties. I believe that absolutely. I have no axe to grind in it. I came on board just a month before that tragedy happened. I was charged by the Secretary with looking into it in great detail, and that is my best judgment.

Mr. NICHOLS. Thank you, Doctor. All right. We have some questions from staff, but in the interest of time, I will leave the record open, and let them ask the questions.

[The following information was received for the record:]

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, DC, September 20, 1985.

Hon. BILL NICHOLS,
Chairman, Investigations Subcommittee, House Committee on Armed Services, Washington, DC.

DEAR MR. CHAIRMAN: I would like to insert some materials into the record of the Subcommittee hearing of September 18, on the subject of the Department of Defense's efforts in the area of medical capability and readiness.

These figures are for the total available capacity and current census for Bethesda Naval Hospital and Walter Reed Army Hospital on September 18, 1985, the date of the Subcommittee's hearing. I believe these figures are helpful in the study of this issue.

I do not think that anyone would disagree that some military hospitals in isolated areas are not fully utilized. However, these facilities must be available in the event of any emergency. Equally as important, major facilities like Walter Reed and Bethesda, while receiving steady use at present, must be available to take a large number of patients from many other areas in a military emergency or other disaster.

I believe Congress should use extreme caution in any attempt to gain savings through the reduction of available military hospitals.

Sincerely yours,

WILLIAM CARNEY, M.C.

MILITARY HOSPITAL BED CAPACITY

	Bethesda Naval Hospital	Walter Reed Army Hospital
Authorized bed capacity	569	950
Temp. authorized bed capacity [1]	476	870
Patient census for September 18, 1985	441	688
Number of Coronary care unit beds	5	8
Number of occupied beds	2	8
Number of Intensive care unit beds	10	53
Number of occupied beds	8	38

MILITARY HOSPITAL BED CAPACITY—Continued

	Bethesda Naval Hospital	Walter Reed Army Hospital
Number of maternity beds	20	24
Number of occupied beds	20	24
Number of nursery beds	12	40
Number of occupied beds	8	20
Number of alcohol rehab. beds	46	0
Number of occupied beds	35	0
Number of psychiatric beds	24	131
Number of occupied beds	23	81
Number of self care beds	64	24
Number of occupied beds	61	23
Surge capacity	704	classified

[1] Due to shortage of staff.

Mr. NICHOLS. Any further business of the subcommittee? No. The subcommittee stands adjourned.

[Whereupon, at 12:41 p.m., the subcommittee was adjourned.]

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